

## DEPARTMENT OF HUMAN SERVICES

### Behavioral Health

#### BEHAVIORAL HEALTH

##### 2 CCR 502-1

*[Editor's Notes follow the text of the rules at the end of this CCR Document.]*

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#### **Statement of Basis and Purpose, Fiscal Impact/Regulatory Analysis and Specific Statutory Authority**

Rules regarding the Care and Treatment of the Mentally Ill were originally adopted on 3/21/1977, and subsequently amended through April 20, 1993 (effective May 30, 1993), by the Department of Institutions.

The purpose of the 1991 revision of these rules is to make the regulations easier to locate within the document, easier to read and to understand; to incorporate policy statement formerly contained in the Division of Mental Health's Procedures Manual; and to add several changes recommended to the Department of Institutions by the Mental Health Advisory Board for Service Standards and Regulations.

These rules were proposed pursuant to Notice of Public Hearing published on November 10, 1991, and after proper notice, a public hearing was conducted on Thursday, December 5, 1991. Written and oral testimony presented to the Department of Institutions was considered in the determination to adopt these rules. The record of the rule-making proceeding demonstrates the need for these regulations; the regulations have been clearly and simply stated; and the regulations do not conflict with other provisions of law. The effective date for these rules is March 1, 1992.

Sections 103.2.A.2 and 103.2.A.3, which were adopted after January 1, 1992 and before January 1, 1993, were not extended by H.B. 93-1131 and therefore expired effective June 1, 1993.

The entire re-write of these rules were adopted following publication at the 4/2/2004 State Board of Human Services meeting, with an effective date of 6/1/2004 (Rule-making #03-5-14-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Performance Improvement, Boards and Commissions Division, State Board Administration.

Addition of rules concerning Acute Treatment Units, Sections 19.500 through 19.568.2 were adopted following publication at the 9/7/2007 State Board of Human Services meeting, with an effective date of 11/1/2007 (Rule-making #07-3-22-2). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Performance Improvement, Boards and Commissions Division, State Board Administration.

Revision of Section 19.421.3 was adopted following publication at the 7/12/2013 State Board of Human Services meeting, with an effective date of 9/1/2013 (Rule-making# 13-5-14-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Enterprise Partnerships, Division of Boards and Commissions, State Board Administration.

Rules regarding care and treatment of the mentally ill, as originally found in 2 CCR 502-1 (Rule Vol. 19), are repealed in their entirety and rewritten as a consolidation of Behavioral Health rules in 2 CCR 502-1 (Rule Vol. 21) as adopted following publication at the 9/6/2013 State Board of Human Services meeting, with an effective date of 11/1/2013 (Rule-making# 13-3-4-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Enterprise Partnerships, Division of Boards and Commissions, State Board Administration.

Revisions to Sections 21.900 through 21.950 were adopted on an emergency basis at the 11/6/2015 State Board of Human Services meeting, with an effective date of 11/6/2015 (Rule-making# 15-10-20-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relations, State Board Administration.

Revisions to Sections 21.900 through 21.950 were adopted as final (permanent) at the 12/4/2015 State Board of Human Services meeting, with an effective date of 2/1/2016 (Rule-making# 15-10-20-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relations, State Board Administration.

Revisions to Sections 21.000 through 21.330 were adopted at the 3/4/2016 State Board of Human Services meeting, with an effective date of 5/1/2016 (Rule-making# 15-08-26-1). Statement of Basis and Purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Strategic Communications and Legislative Relations, State Board Administration.

## **21.000 BEHAVIORAL HEALTH**

### **21.100 DEFINITIONS [Eff. 5/1/16]**

“Acute Treatment Unit” (ATU) means a designated facility or a distinct part of a facility for short-term psychiatric care, which may include substance use disorder treatment. An ATU provides a twenty-four (24) hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services, such as crisis management and stabilization services, than are available on an outpatient basis, as defined in 27-65-102(1), C.R.S.

“Aggrieved” means having suffered actual loss or injury or being exposed to potential loss or injury to legitimate interests as defined in 24-4-102 (3.5), C.R.S.

“Behavioral Health” for the purposes of these rules, behavioral health includes substance use and mental health. “Department” is the Colorado Department of Human Services.

“Community Mental Health Clinic” means a health institution planned, organized, operated, and maintained to provide basic community services for the prevention, diagnosis, and treatment of emotional or mental disorders, such services being rendered primarily on an outpatient and consultative basis.

“Designated Facility” means an agency has applied for and been approved by the department under these rules to provide mental health services.

“Designated Managed Service Organization” means an organization approved and authorized by the Department to manage oversight, quality assurance, and contract compliance of substance use disorder treatment providers within one or more of the seven established geographic sub-state planning areas.

“Individual” means a person seeking or receiving services.

“Inpatient” refers to inpatient hospitalization as well as twenty-four (24) hour residential levels of care.

“Legal Guardian” is an individual appointed by the court, or by will, to make decisions concerning an incapacitated individual's or minor's care, health, and welfare.

“Legal Representative” means one of the following:

- A. The legal guardian of the individual, where proof is offered that such guardian has been duly appointed by a court of law, acting within the scope of such guardianship;
- B. An individual named as the agent in a Power of Attorney (POA) that authorizes the individual to act on the individual's behalf, as enumerated in the POA;
- C. An individual selected as a proxy decision-maker pursuant to Section 15-18.5-101, et seq., C.R.S., to make medical treatment decisions. For the purposes of these rules, the proxy decision-maker serves as the individual's legal representative for the purposes of medical treatment decisions only; or,
- D. A conservator, where proof is offered that such conservator has been duly appointed by a court of law, acting with the scope of such conservatorship.

“Licensed Agency” means an agency approved and licensed under these rules by the Department to provide substance use disorder treatment.

“Office” is the Office of Behavioral Health within the Colorado Department of Human Services.

“Plan of Action” is a description of how an agency plans to bring into compliance any standards identified as out of compliance within a specified time period.

“Placement facility” means a public or private facility that has a written agreement with a designated facility to provide care and treatment to any individual undergoing mental health evaluation or treatment by the designated facility. A placement facility may be a general hospital, nursing care facility, or licensed residential child care facility.

“RCCF” means a residential child care facility licensed pursuant to 12 CCR 2509-8, Section 7.705, et seq., by the Colorado Department of Human Services, Division of Child Welfare.

“Short-Term” psychiatric care means the average lengths of services are from three (3) to seven (7) days.

### **21.105 RIGHT TO APPEAL [Eff. 5/1/16]**

Any licensee or designee adversely affected or aggrieved by these rules or by the Department's decisions in regard to implementation of these rules, has the right to appeal to the Colorado Department of Personnel and Administration, Office of Administrative Courts, and may subsequently seek judicial review of the Department's action in accordance with Section 24-4-101, et seq., C.R.S.

- A. The following actions may be submitted to an Administrative Law Judge for an evidentiary hearing: denial of a license or designation, provisional license, probationary license, revocation, denial of a waiver, limitation of a license, denial of a modification.

- B. After written notification from the Department of intended action, the licensee or designee has twenty one (21) calendar days to submit a written appeal. The appeal must be received by the Division of Behavioral Health within twenty one (21) days from the date the written notification of action letter was sent by the Department.
- C. In all cases except waiver denials, the Department will file a notice of charges with the Office of Administrative Courts to begin the administrative process. In waiver denials, the Appellant's request for appeal shall be forwarded to the Office of Administrative Courts. Once the appellant's request is forwarded to the Office of Administrative Courts, the Department may file a notice of charges.
- D. An answer to the notice of charges shall be due twenty one (21) calendar days after the date of mailing of the notice of charges.
- E. The Office of Administrative Courts shall send out a procedural order directing the course of the proceedings and setting the matter for hearing.
- F. Subsequent to an evidentiary hearing at the Office of the Administrative Courts and the issuance of a final agency decision, a party may seek to appeal the final agency decision through judicial review in accordance with Section 24-4-106, C.R.S.

**21.110 GOVERNANCE [Eff. 11/1/13]**

- A. Licensed and or designated entities by the Department shall be recognized by and allowed to do business in Colorado.
- B. Governance shall provide for and maintain at minimum:
  - 1. Compliance with these rules and applicable federal and state regulations;
  - 2. Agency operating policies and procedures based on these rules, Department policies and procedures, and applicable state and federal regulations;
  - 3. Organizational structures that clearly delineate staff positions, and lines of authority, and supervision;
  - 4. Adequate financial resources to maintain agency personnel, physical facilities, and operations;
  - 5. Physical facilities that meet all current and applicable local and state health, safety, building, plumbing and fire codes and zoning ordinances;
  - 6. Property liability insurance;
  - 7. Professional liability (malpractice) insurance;
  - 8. Accurate, up-to-date individual attendance and payment records; and,
  - 9. A written emergency plan and procedures that address provisions for dealing with medical or natural emergencies. Maps of emergency exits shall be conspicuously posted in each site.

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**21.120 BEHAVIORAL HEALTH LICENSURE AND DESIGNATION**

**21.120.1 GENERAL PROVISIONS [Eff. 5/1/16]**

- A. Any agency licensed and/or designated by the Department shall comply with Sections 21.100 through 21.190 and all rules applicable to the specific behavioral health services for which it is licensed or designated.
- B. The Department will review compliance, at a minimum:
  - 1. Licensed agencies once every two (2) years;
  - 2. Facilities designated to provide mental health services per Title 27, Article 65, C.R.S., annually and all other designated agencies at least once every two (2) years; and,
  - 3. When there is reasonable cause to question the agency's fitness to conduct or maintain a license or designation.
- C. Compliance review of sub-contractors and affiliate agencies shall be at the discretion of the Department. Review will be limited to those services that are provided pursuant to contract or affiliation agreement with the licensed or designated agency.
- D. Based on compliance issues identified through application review and on-site inspection, the agency may be issued a provisional or probationary license or designation.
- E. Applicants that are in full compliance shall be granted a Department license to provide substance use disorder services and/or designated to provide mental health services for up to two (2) consecutive years from the date granted.
- F. Licenses and designations shall be displayed in a prominent, publicly accessible place within each agency and or site.
- G. Current licenses and designations shall remain in effect during the approval process when license and designation applications are received by the Department on or before current expiration dates.
- H. An agency whose license or designation is not current shall not indicate in any form or manner that it is licensed or designated and shall not provide behavioral health services requiring a license or designation.
- I. Any agency site that has not provided behavioral health services specific to its license or designation status for two (2) years shall be reviewed for termination of licensure or designation.
- J. Applicants may appeal licensing decisions in accordance with the state Administrative Procedure Act, as found in Section 24-4-101, et seq., C.R.S.

**21.120.2 LICENSING PROCEDURES FOR AGENCIES PROVIDING SUBSTANCE USE DISORDER SERVICES**

**21.120.21 Criteria [Eff. 11/1/13]**

- A. Providers shall obtain a license if:
  - 1. Required by statute to be licensed by the Department;

2. They receive public funds to provide substance use disorder treatment or substance use disorder education;
  3. They provide such treatment to individual populations whose referral sources require them to be treated in agencies licensed by the Department; or,
  4. They are acquiring existing agencies or sites licensed by the Department.
- B. Licenses for treatment and education services and levels of care are required for each physical site.
- C. A license is not transferable from one licensed agency to another, from one treatment site to another, or from a licensed agency to an unlicensed organization or individual.
- D. Hours of education and treatment provided by agencies whose license is not currently in effect may not count toward fulfilling individual obligations to courts; probation; parole; Colorado Department of Revenue, Motor Vehicle Division; and, other referral sources.
- E. Agencies funded by the Department or a by a designated Managed Service Organization shall be licensed to treat individuals involuntarily committed to treatment in accordance with Section 21.270.

**21.120.22 Initial Licenses [Eff. 11/1/13]**

- A. Applicants for an initial license to provide substance use disorder services shall submit a completed application with required documentation and fees.
- B. An agency may be approved for licensure, granted provisional approval, or have its application denied. The applicant shall be advised of the decision in writing within sixty (60) business days of the initial on-site evaluation.
- C. An applicant not in compliance may have its license application returned by certified mail with written summaries of deficiencies and notification that the license application is denied. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.120.2 of these rules. Application fees may not be refunded.

**21.120.23 Provisional Licenses [Eff. 11/1/13]**

- A. A provisional license may be granted for a period not to exceed ninety (90) calendar days if after initial inspection and review:
1. The provider is in substantial compliance with these rules and regulations and is temporarily unable to conform to all the minimum standards required under these rules. No provisional license shall be issued to a provider if the operations may adversely affect individual health, safety, or welfare;
  2. Compliance will be achieved within a reasonable period of time;
  3. The provider has a reasonable written plan or schedule for achieving compliance; and,
  4. The provider shall provide proof that attempts are being made to conform and comply with applicable rules.

- B. A second provisional license for a period not to exceed ninety (90) calendar days may be granted if substantial progress continues to be made, and it is likely compliance can be achieved by the date of expiration of the second provisional license.
- C. During the term of the provisional license, reviews and on-site inspections may be conducted to determine if the applicant is in compliance and meets the requirements for a license.
- D. Initial applicants who have completed all provisions and are found to be in compliance prior to the expiration of the provisional license shall be granted a license for up to two (2) consecutive years from the date the original provisional license was issued.
- E. If the applicant does not come into compliance during the provisional licensing period, the application for a two (2) year license shall be denied. A denied application shall be returned by certified mail with written summaries of deficiencies and notification that the provisional license is no longer in effect as of ten (10) days from the date the letter was mailed. Original application fees shall not be refunded. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.120.2 of these rules.

**21.120.24 License Renewal [Eff. 11/1/13]**

- A. An agency seeking renewal shall provide the Department with a completed license application and the applicable fee at least sixty (60) days prior to the expiration of the existing license.
- B. License renewal applications received by the Department after the current license expiration date shall be returned by certified mail with written notification that the license is no longer in effect. Applicants may reapply for an initial license in accordance with Section 21.120.2 of these rules.
- C. License renewal applications that are received by the Department before the expiration date of current licenses shall be reviewed and on-site inspections may be conducted to determine the agency's compliance with applicable sections of these rules.
- D. The agency licensee shall be notified in writing of non-compliance areas and the need for a plan of action as outlined in Section 21.120.6. A probationary license may be granted.
- E. An agency in compliance with the applicable Department rules and state and federal regulations shall be granted a license renewal effective as of the expiration dates of the current license.

**21.120.25 Probationary License [Eff. 11/1/13]**

- A. At the Department's discretion, a probationary license may be granted to an agency out of compliance with applicable Department, state or federal regulations prior to issuance of a renewal license or during a current license term. The agency will be notified in writing of non-compliance areas and the need for a plan of action (see Section 21.120.6).
- B. A probationary license will replace the current license for a period not to exceed ninety (90) calendar days.
- C. Administrative and treatment activities may be limited by a probationary license while the agency addresses corrective actions.
- D. A probationary license may be re-issued for a period not to exceed ninety (90) calendar days if substantial progress continues to be made and it is likely that compliance can be achieved by the date of expiration of the second probationary license.

- E. If the licensee fails to comply with or complete a plan of action in the time or manner specified, or is unwilling to consent to the probationary license, the modification to a probationary license shall be treated as a revocation of the licensee and s/he shall be notified by certified mail that the probationary license is no longer in effect as of ten (10) days from the date the letter was mailed. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.120.2 of these rules.

**21.120.26 License Modification [Eff. 11/1/13]**

- A. An agency shall submit a license modification application and written documentation demonstrating compliance with all applicable Department rules, policies and procedures, a minimum of thirty (30) calendar days prior, in the following circumstances:
1. Adding, selling, moving or closing agencies, sites, services, or levels of care;
  2. Changing the agency name;
  3. Changing agency governance.
- B. Failure to submit license modification applications and required documentation within thirty (30) calendar days may result in the agency, specific sites, and or levels of care not being licensed.
- C. Application fees for a license modification are not required.

**21.120.27 Limited License [Eff. 11/1/13]**

- A. At the Department's discretion, a limited license may be issued to an agency to prevent or address a perceived conflict of interest and/or a dual relationship within the agency that may negatively impact persons receiving services.
- The following include, but are not limited to, circumstances where there may be a perceived conflict of interest and/or a dual relationship exists within an agency:
1. The sharing of information across systems that could negatively impact the individual; or,
  2. A financial interest of the agency that may have negative treatment and/or referral implications pertaining to the individual; or,
  3. The combining of professional roles within the agency that is incompatible to the best interests of the individual(s) receiving treatment.
- B. Limitation of the license may include, but is not limited to:
1. Limiting the specific clientele an agency may serve;
  2. Limiting the specific location(s) where an agency may or may not offer services; or,
  3. Limiting the specific level of care that may be provided pursuant to the license.
- C. If an applicant is unwilling to consent to the limitation on the license, the limitation shall be treated as a denial and s/he may appeal (see Section 21.105); or upon remedying the noted perceived conflict of interest and/or a dual relationship, may re-apply for an initial license in accordance with Section 21.120.2 of these rules.

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**21.120.3 FACILITIES DESIGNATED TO PROVIDE MENTAL HEALTH SERVICES [Eff. 5/1/16]**

Facilities designated to provide mental health services may be:

- A. A general or psychiatric hospital licensed or certified by the Colorado Department of Public Health and Environment;
- B. A community mental health center Licensed by the Colorado Department of Public Health and Environment or a community mental health clinic;
- C. An acute treatment unit licensed by the Colorado Department of Public Health and Environment; or,
- D. A residential child care facility licensed by the Colorado Department of Human Services, Division of Child Welfare.

Applicant facilities shall identify any parent organization ultimately responsible for their operation.

**21.120.31 Application of Rules [Eff. 5/1/16]**

- A. Designated facilities that are hospitals or acute treatment units shall comply with all applicable rules including provisions contained in Section 21.280:
- B. Designated facilities that are community mental health centers pursuant to Section 27-66-101, C.R.S., shall comply with Sections 21.130 through 21.200.15, where applicable, and Section 21.280. Treatment provisions, as contained in Sections 21.280.3 through 21.280.9 shall apply to only those individual being treated involuntarily pursuant to Title 27, Article 65, C.R.S.
- C. Designated facilities that are community mental health clinics shall comply with Sections 21.130 through 21.200.15 and Sections 21.280.21 through 21.280.22.
- D. Designated facilities that are residential child care facilities (RCCF) shall follow Section 21.120.3 through 21.120.44 and 21.200 through 21.200.15, where applicable. RCCFs designated to provide mental health services pursuant to Title 27, Article 65, C.R.S. shall follow Sections 21.200, where applicable, and Section 21.280.
- E. Designated managed service organizations (DMSO) shall only comply with 21.120.5 and 21.120.8.

**21.120.32 Mental Health Services Pursuant to Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness Designations [Eff. 5/1/16]**

- A. A facility meeting the criteria in Section 21.120.3, excluding community mental health clinics, may apply to the Department to become designated to provide any or all of the following services:
  - 1. Seventy-two (72) hour treatment and evaluation;
  - 2. Short-term treatment; or,
  - 3. Long-term treatment.

- B. Facilities designated for seventy-two (72) hour treatment and evaluation, short-term, or long-term treatment shall have a person who is licensed in Colorado to practice medicine or a certified Colorado psychologist, either employed or under contract, who is responsible for the evaluation and treatment of each individual. Hospital staff privileges shall be an acceptable form of contractual arrangement. The professional person licensed in Colorado to practice medicine or a certified Colorado psychologist may delegate part of his/her duties, except as limited by licensing statutes or these rules, but s/he shall remain responsible at all times for the mental health treatment administered.

**21.120.33      Seventy-Two (72) Hour Treatment and Evaluation Facilities [Eff. 5/1/16]**

- A. Facilities that are designated as seventy-two (72) hour treatment and evaluation facilities may detain on an involuntary basis persons placed on a seventy-two (72) hour hold for the purpose of evaluation and treatment.

- B. Exclusion of Saturdays, Sundays, and Holidays

Evaluation shall be completed as soon as possible after admission. The designated treatment and evaluation facility may detain a person for seventy-two (72) hour evaluation and treatment for a period not to exceed seventy-two (72) hours, excluding Saturdays, Sundays and holidays if evaluation and treatment services are not available on those days. For the purposes of these rules, evaluation and treatment services are not deemed to be available merely because a professional person licensed in Colorado to practice medicine or a certified Colorado psychologist is on call during weekends and holidays.

**21.120.34      Short-Term and Long-Term Treatment Facilities [Eff. 5/1/16]**

- A. Facilities that are designated as short-term treatment facilities may involuntarily detain individuals for short-term (a period of not more than three months) or extended short-term care and treatment (a period of not more than an additional three months).

- B. Facilities that are designated as long-term treatment facilities may involuntarily detain individual for long-term care and treatment (a period not to exceed six months) or extended long-term treatment (a period of not more than additional six months).

- C. Every person receiving treatment for a mental health disorder by a designated short-term or long-term facility shall upon admission be placed under the care of a person who is licensed in Colorado to practice medicine or a certified Colorado psychologist and employed by or under contract with the designated facility.

**21.120.35      Mental Health Centers and Community Mental Health Clinics [Eff. 5/1/16]**

- A. Mental health centers and community mental health clinics shall use membership on the governing board or equivalent for soliciting input regarding issues which impact persons receiving care. Input shall be solicited from adults, children and adolescents receiving services, and their parents or guardians. The input shall be taken into consideration by management or the governing board during decision-making processes.

- B. Emergency/crisis services and evaluation under Sections 27-65-105 and 106, C.R.S., shall be provided twenty-four (24) hours per day including Saturdays, Sundays and holidays. Initial responses to emergencies shall occur either by telephone within fifteen (15) minutes of the call, within one (1) hour of contact in urban and suburban areas, or within two (2) hours of contact in rural and frontier areas.

**21.120.4 DESIGNATION PROCEDURES [Eff. 11/1/13]**

- A. Facilities applying for designation shall submit an application to the Department on a state approved form.
- B. Facilities providing twenty-four (24) hour inpatient or acute crisis care, must apply for a separate designation based on the unique physical address of each site.
- C. Except in emergency circumstances affecting the facility's ability to provide evaluation and treatment services, a facility seeking to exclude Saturdays, Sundays and holidays from the seventy-two (72) hour limitation on detaining persons for evaluation and treatment must supply in its application for designation or re-designation documentation to establish that it does not have evaluation services available on these days due to the limited availability of a professional person licensed in Colorado to practice medicine or a certified Colorado psychologist.
- D. Receipt of the application shall be acknowledged in writing and state what additional information or documents, if any, are required for review prior to an on-site evaluation.
- E. For initial designation applications, the applicant shall be advised in writing within sixty (60) calendar days of initial on-site evaluation of the decision of the Department. The facility may be approved for designation, granted provisional approval, or the application may be denied.
- F. A facility that is found to be in compliance with these rules shall be approved as a facility designated to provide mental health services effective for up to a two (2) year period.
- G. Designations shall be automatically revoked or deemed lapsed for any facility whose license to operate as a health care or residential child care facility has been withdrawn, revoked or allowed to lapse.
- H. If the application for designation is denied, the reason(s) for denial shall be provided in a certified letter. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for designation in accordance with Sections 21.120.3 and 21.120.4 of these rules.

**21.120.41 Provisional Designation [Eff. 11/1/13]**

- A. Provisional approval may be granted for a period not to exceed ninety (90) calendar days if, after initial inspection and review of a facility:
  - 1. The facility is in substantial compliance with these rules, and is temporarily unable to conform to all the minimum standards required under these rules. No provisional designation shall be issued to a facility if the operation of the facility may adversely affect individual health, safety, or welfare;
  - 2. Compliance will be achieved within a reasonable period of time; and,
  - 3. The facility has a reasonable plan or schedule in writing for achieving compliance.
- B. The facility shall provide proof that attempts are being made to conform and comply with applicable rules.
- C. A second provisional approval for a period not to exceed ninety (90) calendar days may be granted under the same criteria if necessary to achieve compliance.

- D. If the facility is not able to come into compliance within one hundred and eighty (180) calendar days from date initial provisional license granted, the application may be denied.

**21.120.42 Re-Designation [Eff. 11/1/13]**

- A. Approved facilities shall apply every two (2) years for designation prior to the expiration date.
- B. Facilities designated to provide care and treatment to persons with mental health disorders pursuant to Section 27-65-101, et seq., C.R.S., shall receive an annual on-site review for compliance. All other designated facilities shall be reviewed on-site at least every two (2) years.
- C. Facilities shall be notified in writing of non-compliance areas and the need for a plan of action as outlined in Section 21.120.6. A probationary designation may be granted.
- D. A facility in compliance with applicable Department rules and state and federal regulations shall be granted designation effective as of the expiration date for a period not to exceed two (2) years.

**21.120.43 Probationary Designation [Eff. 11/1/13]**

- A. A probationary designation may be granted to a licensee out of compliance with applicable Department or state and federal regulations prior to issuance of a renewal designation or during a current designation period. The facility will be notified in writing of non-compliance areas and the need for a plan of action (see Section 21.120.6).
- B. A probationary designation will replace the current designation for a period not to exceed ninety (90) calendar days.
- C. Administrative and treatment activities may be limited by a probationary designation while the facility addresses corrective actions.
- D. A probationary designation may be re-issued for a period not to exceed ninety (90) calendar days if substantial progress continues to be made and it is likely that compliance can be achieved by the date of expiration of the second probationary license.
- E. If the facility fails to comply with or complete a plan of action in the time or manner specified, or is unwilling to consent to the probationary designation, the modification to a probationary designation shall be treated as a revocation of the designation and the facility shall be notified by certified mail of the deficiencies, reason for action, and that the probationary designation is no longer in effect as of ten (10) days from the date the letter was mailed. If the facility disagrees with the decision, it may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for a designation in accordance with Sections 21.120.3 and 21.120.4 of these rules.

**21.120.44 Change in Designation [Eff. 11/1/13]**

If a facility makes a change in its designation status or decides to drop its designation, it shall notify the Department in writing not later than thirty (30) calendar days prior to the desired effective date. The facility shall submit a written plan for the transfer of care for the individuals with mental health disorders if the facility will no longer treat those individuals. This plan shall be submitted no later than ten (10) business days prior to the effective date.

**21.120.5 DESIGNATED MANAGED SERVICE ORGANIZATION (DMSO) [Eff. 11/1/13]**

- A. The Office of Behavioral Health, within the Department, has the authority pursuant to Section 27-80-107, C.R.S., to designate a Managed Service Organization (MSO) responsible for service delivery to eligible persons, as described in the annual federal Substance Abuse Prevention and Treatment Block Grant application, residing in each of the seven (7) defined geographic regions.
- B. Once designated, each managed service organization shall be reviewed annually for compliance pursuant to Section 27-80-107, C.R.S., and Department rules and contract.
- C. MSO's shall follow all applicable Department rules.

**21.120.51 Role of Designated Managed Service Organizations (DMSO) [Eff. 11/1/13]**

- A. Each DMSO will oversee the expenditure of Department funds in providing effective population-specific substance use disorder treatment and related services to the priority populations identified in each applicable contract.
- B. Each DMSO will develop and monitor a network of licensed providers of substance use disorder services to deliver a full continuum of care as defined in the Department contract within the designated geographic regions of the state.
- C. Each DMSO will ensure the delivery of population-specific services to priority populations as defined in the Department contract, to include individuals and families in need of substance use disorder treatment and related services.

**21.120.52 Reporting Requirements [Eff. 11/1/13]**

- A. Each DMSO must maintain a fiscal reporting system that complies with state and federal requirements.
- B. Each DMSO must maintain an individual-services reporting system that complies with state and federal requirements.

**21.120.53 Service Provision [Eff. 11/1/13]**

When a DMSO provides substance use disorder treatment or a related service to any individual, it must be licensed by the Department and demonstrate compliance with all applicable rules.

**21.120.54 Monitoring and Quality Improvement [Eff. 11/1/13]**

- A. Each DMSO must demonstrate ethical, legal, and solvent fiscal practices, and must maintain a system for periodic review of its contracts, billing and coding procedures, billing records, contractual requirements, and legal requirements.
- B. Each DMSO must maintain a system for periodic review of its contractors to identify any intentional or unintentional wrongdoing and to ensure that they are exercising ethical, legal, and solvent fiscal practices.

**21.120.55 Revocation [Eff. 11/1/13]**

- A. Designation shall be revoked for reasons including but not limited to those in Section 21.120.8.
- B. Prior to starting a revocation process, the DMSO shall be notified of the facts or conduct that may warrant such action. A plan of action may be required (see Section 21.120.6).

- C. Where there are grounds to find that the DMSO has engaged in deliberate and willful violation or that the public health, safety, or welfare requires emergency action, the Department may summarily suspend the designation pending proceedings for suspension or revocation.
- D. Written notification of action to revoke a designation shall be sent to the DMSO. Except in cases of deliberate and willful violation or of substantial danger to the public health and safety, such notice shall be sent at least ten (10) working days before the date such action goes into effect, and shall include reasons for the action and rights to the appeal process specified in the State Administrative Procedure Act, pursuant to Sections 24-4-105 through 107, C.R.S.

**21.120.6 LICENSE AND DESIGNATION REVIEW PROCESS AND PLANS OF ACTION [Eff. 11/1/13]**

- A. If after review or pursuant to a complaint, that a licensed or designated agency, contractor, or affiliate is not in compliance with these rules, the organization shall be notified in writing, within thirty (30) business days, of the specific items found to have been out of compliance.
- B. If the agency does not agree with any or all of the findings regarding non-compliance, the agency has ten (10) business days from the receipt of non-compliance notice to dispute the findings by submitting evidence to the Department.

The agency shall receive a written response within thirty (30) business days of the review of submitted evidence.

If the submitted information is sufficient, the agency shall be determined in compliance with these rules.

If the agency continues to be found out of compliance with these rules, the agency shall have thirty (30) business days from the date of receipt of the review findings to submit a plan of action. The plan shall include anticipated dates for achieving full compliance.

- C. If the agency does not dispute the findings, it shall have thirty (30) business days from the receipt of the notice of non-compliance to submit a written plan of action addressing the compliance issues. The plan shall include anticipated dates for achieving full compliance within ninety (90) business days of the submitted plan.
- D. After reviewing the agency's plan of action, the Department may take action as follows:
  - 1. Approve the proposed plan and schedule for achieving full compliance; or,
  - 2. Approve a modified plan and schedule for achieving full compliance; or,
  - 3. Initiate action to revoke, suspend, make probationary, limit, or modify the license or designation of the agency as provided in Section 24-4-104, C.R.S.; and,
  - 4. In cases where a plan of action has been approved, the agency shall remain licensed or designated subject to the achievement of the plan of action.

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**21.120.7 WAIVERS [Eff. 11/1/13]**

Every licensed and designated agency shall comply in all respects with applicable rules. Upon application to the Department, a waiver of the specific requirements of these rules may be granted in accordance with this section, unless the requirements are otherwise required by state or federal law, and individual rights shall not be waived.

**A. Time Period**

A waiver of a specific rule may be granted to a licensed or designated agency, or an agency seeking initial application, for a period not to exceed the two year licensing or designation period. The waiver may be renewed at the time of re-licensing or designation.

**B. Compliance with all Other Regulations**

Agencies applying for or granted a waiver shall be in compliance with local, state and federal regulations, shall not have outstanding findings with regulatory authorities, and be in good standing with meeting any and all contractual requirements related to providing behavioral health services.

**C. Grounds for a Waiver**

A waiver may be granted upon a finding that:

1. The waiver would not adversely affect the health, safety and welfare of the individuals; and/or,
2. Either it would improve care or application of the particular rule would create a demonstrated financial hardship on the organization seeking the waiver.

**D. Burden of Proof**

The agency seeking the waiver has the burden of proof. Consideration shall be given as to whether the intent of the specific rule has been met.

**E. Placement Facilities**

When a designated agency provides mental health services through a placement facility and a waiver is sought for such services, the designated agency and not the placement facility shall request the waiver.

**F. Requests for Waivers**

Requests for waivers shall be submitted to the Department on the state prescribed form. The request shall include:

1. A detailed description of the behavioral health services provided by the agency;
2. The rule section proposed to be waived and the waiver's effect on the health, safety and welfare of the individuals served;
3. The expected improvement in the care of individuals;
4. If there would be undue financial hardship on the agency, and to what degree; and,

5. Signature of the Board President, Director of the agency, or designee.

G. Decision Process

Unless additional time is required to make inspections or obtain additional information from the agency, the agency shall be notified in writing of the decision within thirty (30) calendar days following the date of receipt of the completed waiver application.

H. Appeal Rights

An agency may appeal the decision of the Department regarding a waiver application as provided by the Colorado Administrative Procedure Act, Sections 24-4-104 and 24-4-105, C.R.S.

**21.120.8 LICENSE AND DESIGNATION REVOCATION, DENIAL, SUSPENSION, LIMITATION OR MODIFICATION [Eff. 11/1/13]**

A. At the Department's discretion, a license or designation may be revoked, denied, suspended, modified or have limited licenses or designation. Written notification of the basis for action shall be sent by certified mail to the last known address of the agency, and is effective ten (10) days from the date the letter was mailed. If the affected agency disagrees with the decision, it may appeal per Section 21.105.

B. A license or designation may be summarily suspended pending proceedings for suspension or revocation in cases of deliberate or willful violation of applicable statutes and regulations or where the public health, safety, or welfare requires emergency action.

C. A license or designation may be revoked, denied, suspended, modified, or limited for reasons including, but not limited to, the following:

1. Non-compliance with these rules, applicable federal and state laws and regulations, or contracting requirements.
2. Negligence resulting in risk to individuals, staff, public health or safety;
3. Knowingly using or disseminating misleading, deceptive, or false information about other agencies including, but not limited to, advertising;
4. Exercising undue influence on or otherwise exploiting individuals to obtain or sell services, goods, property, or drugs for financial or personal gain;
5. Accepting commissions, rebates, or other forms of remuneration for referring persons to or by the licensed or designated agency;
6. Evidence of agency fraud or misrepresentation;
7. Failure to provide persons with information required by these rules and applicable state and federal statutes, rules, and regulations;
8. Failure to submit required data in an accurate and timely manner to the Department or its authorized representatives;
9. Withholding access to clinical, staff, or fiscal records, or administrative information when requested by the Department;

10. Sale, use or distribution of alcohol or illicit drugs, or unauthorized sale or distribution of prescription or over-the-counter drugs on treatment premises or during treatment activities off premises;
11. Knowingly using, and/or disseminating false information about these rules, Department rules and state or federal regulations, or other information essential to interpreting or managing an individual's status, case management or interagency coordination.
12. Commits a fraudulent insurance act as defined in Section 10-1-128, C.R.S.
13. Failure to comply with a written plan of action.

**21.130 DATA REQUIREMENTS [Eff. 11/1/13]**

Licensed and designated organizations shall provide accurate and timely submission of required data to the Department identified data collection systems or its authorized representatives and retain a copy in treatment record.

**21.140 CRITICAL INCIDENT REPORTING [Eff. 11/1/13]**

A critical incident is any significant event or condition that must be reported within twenty-four (24) hours to the Department that is of public concern and/or has jeopardized the health, safety and/or welfare of individuals or staff.

- A. The Department may conduct scheduled or unscheduled site reviews for specific monitoring purposes and investigation of critical incidents reports in accordance with:
  1. CDHS policies and procedures;
  2. Regulations that protect the confidentiality and individual rights in accordance with Sections 27-65-101, et seq., C.R.S.; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and 42 CFR, Part 2; no amendments or later editions are incorporated. A copy is available for inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library.
  3. Controlled substance licensing, Title 27, Article 82, C.R.S.; Section 27-80-212, C.R.S., and Section 18-18-503, C.R.S.
- B. The Department shall have access to relevant documentation required to determine compliance with these rules.
- C. The agency shall:
  1. Establish written policies and procedures for reporting and reviewing all critical incidents occurring at the facility;
  2. Submit Critical Incidents reports to the Department according to state prescribed forms. This is not in lieu of other reporting mandated by state statute or federal guidelines;
  3. Make available a report with the investigation findings for review by the Department, upon request; and,
  4. Maintain critical incidents reports for a minimum of three years following the incident.

- D. Nothing in this section shall be construed to limit or modify any statutory or common law right, privilege, confidentiality or immunity.

**21.150 QUALITY IMPROVEMENT [Eff. 11/1/13]**

- A. The agencies and programs that the Department contracts with, licenses, or designates, shall have a quality improvement program designed to monitor, evaluate, and initiate activities to improve the quality and effectiveness of administrative and behavioral health services.
- B. The agency shall adopt and implement a written quality improvement plan that includes, at a minimum the following processes:
1. Clinical quality measurement of performance.
  2. Determine the appropriateness and effectiveness of treatment through a clinical review of a representative sample of open and closed records at a minimum of every six (6) months.
  3. Identify and respond to trends concerning significant events, risks, emergency procedures, critical incidents as defined in Section 21.140, and grievances as defined in Section 21.180.
  4. Incorporate documented quality improvement findings into clinical and organizational planning, decision making, and to develop staff and individual educational programs.
  5. Evaluate annually and update the quality improvement plan as necessary. A copy of the annual findings and report shall be available for review.

**21.160 PERSONNEL**

**21.160.1 GENERAL PROVISIONS [Eff. 11/1/13]**

- A. The organization shall have written personnel policies and procedures that include:
1. Personnel (including contracted staff, interns, and volunteers) shall have access to and be knowledgeable about the organization's policies, procedures, and state and federal laws and regulations relevant to their respective duties.
  2. Personnel are assigned duties that are commensurate with documented education, training, work experience, and professional licenses and certifications. Licensed or certified staff shall perform duties in accordance with applicable statutes, rules and regulations.
  3. Training
    - a. The organization shall document the evaluation of applicable previous related experience for volunteers and for staff, and ensure that these personnel have all of the training, including on-the-job training, required in this section.
    - b. All staff shall be given on-the-job training or have related experience in the job assigned to them. They shall be supervised until they have completed on-the-job training appropriate to their duties and responsibilities, or have had previous related experience evaluated.

- c. The organization shall maintain records documenting completion of all required training, or review of evaluation of previous related experience.
  - d. Volunteers having direct individual contact shall receive training appropriate to their duties and responsibilities.
  - e. Personnel shall receive the following training when first hired and on a periodic basis:
    - 1) Training specific to the particular needs of the populations served;
    - 2) Orientation of the physical plant;
    - 3) Emergency preparedness;
    - 4) Individual rights of the population served;
    - 5) Confidentiality (individual privacy and records privacy and security); and,
    - 6) Training on needs identified through the quality improvement program.
- B. Documentation of training, including topics and attendance, shall be maintained in personnel files or organization training log.
- C. Personnel files for each staff shall be maintained by the organization.
- 1. Files of current staff shall be available onsite for review by the Department.
  - 2. Files shall include documentation of:
    - a. Job description that shall detail minimum qualifications, core competencies, duties, and supervisory structure;
    - b. Education and work experience; and
    - c. Background investigations as described in Section 21.160.2.

**21.160.2 BACKGROUND CHECKS AND EMPLOYEE VERIFICATION [Eff. 11/1/13]**

- A. Pre-employment background investigations:
- 1. Shall be required for all staff, interns and volunteers who have direct contact with individuals receiving services.
  - 2. Take place at submission of an initial Office of Behavioral Health license or designation application or take place at pre-employment.
  - 3. Consist of at least the following:
    - a. A criminal background check performed by the Colorado Bureau of Investigation; and
    - b. A name search with Trails if direct contact with individuals under the age of eighteen.

- B. Pre-employment inquiries:
  - 1. The agency shall verify license, certification, and a check of disciplinary action through the Colorado Department of Regulatory Agencies; and,
  - 2. Complete a reference check.
- C. Organizations shall maintain evidence of background investigations and employee verification in personnel files.
- D. The organization shall have written criteria for evaluating which convictions or complaints make an applicant unacceptable for hire or a staff unacceptable for retention.
- E. The organization shall incur the costs of obtaining a criminal history and background check of potential employees.
- F. The organization shall develop and implement written criteria for:
  - 1. Routine monitoring of employee credentials and disciplinary actions; and,
  - 2. Reporting requirements of investigations, indictments, or convictions that may affect employee's ability to carry out his/her duties or functions of job.

## **21.170 RECORDS CARE AND RETENTION**

### **21.170.1 GENERAL PROVISIONS [Eff. 11/1/13]**

- A. Agencies shall assure that all paper and electronic records are maintained to prevent unauthorized access in accordance with Federal Confidentiality Law 42 CFR Part 2 and the Health Insurance Portability and Accountability Act (HIPAA); no amendments or later editions are incorporated. Copies are available for inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library.
- B. For outpatient agencies:
  - 1. Individual records for adults shall be retained for seven (7) years from date of discharge from agency.
  - 2. For individuals who are under eighteen (18) years of age when admitted to the agency, records shall be retained until the individual is twenty five (25) years of age.
- C. For inpatient agencies:
  - 1. Individual records for adults shall be retained for ten (10) years from date of discharge from agency.
  - 2. For individuals who are under eighteen (18) years of age when admitted to the agency, records shall be retained until the individual is twenty eight (28) years of age.
- D. All records are to be disposed in accordance with State and Federal confidentiality statutes and regulations.
- E. Disposal services commissioned by an agency to dispose of individual records shall sign Qualified Service Organization Agreements or Business Associate Agreements.

- F. Staff having access to individual records shall be knowledgeable of state and federal statutes, policies, and procedures which protect individual identity and service information from unauthorized access and disclosure.
- G. Agencies shall develop policies and procedures that protect individual identity and treatment information when transporting electronic and written records.
- H. Agencies shall establish guidelines for reporting breach or potential loss of individual identity and service information in accordance with state and federal confidentiality statutes and regulations.
- I. Records shall be accessible to agency staff and the Department.
- J. Agencies that are closing or acquired by another agency shall protect individual identity per state and federal regulations.

**21.170.2 CONFIDENTIALITY [Eff. 11/1/13]**

- A. The confidentiality of the individual record, including all medical, mental health, substance use, psychological and demographic information shall be protected at all times, in accordance with all applicable state and federal laws and regulations.
- B. The information in this section shall not be construed to limit the access of duly authorized representatives of the Department to confidential material for purposes of assuring compliance with these rules. Such duly authorized representatives of the Department are obligated to protect the confidentiality of any individual information reviewed.

**21.170.3 RELEASE OF INFORMATION [Eff. 11/1/13]**

- A. An agency that is licensed or designated by the Department must comply with release of information regulations per 42 CFR Part 2 and the Health Insurance Portability and Accountability Act (HIPAA); no amendments or later editions are incorporated. Copies are available for inspection at the Colorado Department of Human Services, Office of Behavioral Health, Director of Community Programs, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library.
- B. The signed release of information shall state, at a minimum:
  - 1. Persons who shall receive the information;
  - 2. For what purpose;
  - 3. The information to be released;
  - 4. That it may be revoked by the individual, parent, or legal guardian at any time;
  - 5. That the release of information shall be time limited up to two (2) years.
- C. Records shall be released to the staff of the governor's designated Protection and Advocacy System for Individuals with Mental Illness, per Section 27-65-121(1)(i), C.R.S., under the following guidelines for all records of:
  - 1. Any individual who is an individual of the system or the legal guardian, conservator, or other legal representative of such individual has authorized the system to have access;

2. Any individual with a mental health disorder, who has a legal guardian, conservator, or other legal representative, with respect to whom a complaint has been received by the system or with respect to whom there is probable cause to believe the health or safety of the individual is in serious and immediate jeopardy, whenever:
    - a. Such representative has been contacted by such system upon receipt of the name and address of such representative;
    - b. Such system has offered assistance to such representative to resolve the situation;
    - c. Such representative has failed or refused to act on behalf of the individual.
- D Whenever a family member or other party requesting information, not including the agency, requests that information revealed to treating personnel remain confidential, such information shall not be released unless otherwise provided by law or court order.
1. Whenever confidential information provided by a family member or other party providing information is ordered released, attempts shall be made to notify the family member or informant of the release of information by the individual who has obtained the court order.
  2. The fact that confidential information is being withheld may be disclosed to individuals requesting the information, but if the individual's attorney has requested the information, the fact that confidential information is being withheld shall be disclosed.

**21.170.4 CONSENTS [Eff. 11/1/13]**

- A. A written agreement shall be executed between the agency and the individual or the individual's legal representative at the time of admission. The parties may amend the agreement provided such amendment is evidenced by the written consent of both parties. No agreement shall be construed to relieve the organization of any requirement or obligation imposed by law or regulation.
- B. Individual consents shall include consent to treatment.
- C. Services shall involve families and significant others with written individual consent, unless clinically contraindicated.
- D. For minor's consent, please review Care of Children, Youth, and Families in Section 21.200.13.
- E. For opioid medication assisted treatment consent, see Section 21.320.

**21.180 GRIEVANCE [Eff. 11/1/13]**

- A. The agency shall establish a uniform procedure for prompt management of grievances brought by individuals accessing, receiving or being evaluated for services and their family members. The organization shall develop policies and procedures for handling grievances. A grievance shall mean any expression of dissatisfaction about any matter related to provided services, and shall be accepted verbally or in writing.
- B. The agency shall provide a fair and accessible grievance resolution process, which shall provide the individual with a resolution no later than fifteen (15) business days from submission of the grievance. If the grievance is received verbally the representative shall create a written documentation of the grievance.

- C. The agency shall designate a representative, who shall be available to assist individuals in resolving grievances, and who shall have no involvement in the clinical or regular care of the individual.
- D. The agency shall educate service recipients and their representatives about the mechanisms in place for filing grievances. This education shall include rights, and internal grievance process and procedures, and the name, contact information, and responsibilities of the designated representative within the agency. Appropriate contacts for external appeal shall also be provided, which may include, but are not limited to, the following: the Colorado Department of Regulatory Agencies, the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, or the governor's designated Protection and Advocacy System for Individuals with Mental Illness. Documentation in the records shall include dated signature of the individual receiving the information.
- E. A notice of rights, grievance procedure, the representative's name, office location, responsibilities, and telephone number shall be posted within the agency in prominent locations where persons access, receive or are evaluated for services.
- F. The agency shall maintain a record of submitted grievances, separate from the individual records that include the date, the type of grievance, and the outcome of investigation. Data shall be reported annually to the Department.

## **21.190 DOCUMENTATION IN INDIVIDUAL RECORDS**

### **21.190.1 DEFINITIONS [Eff. 5/1/16]**

"Admission Summary" is a brief review of assessments and other relevant intake data, including screenings, which summarizes the current status and provides a basis for individualized service planning.

"Assessment" is a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment and referral. This information establishes justification for services.

"Best Practices" are interventions, techniques, and treatment approaches that have some quantitative data showing positive treatment outcomes over a period of time, but may not have enough research or replication to be considered an evidence-based approach.

"Case Management" means activities that are intended to help individuals gain access to behavioral health and supportive services (including social, educational, and medical) that are coordinated and appropriate to the changing needs and stated desires of the individual over time. Activities include, but are not limited to: service planning, referral, monitoring, follow-up, advocacy, and crisis management.

"Chief Complaint/Presenting Problem" means the reason/concern/motivation that prompts the client to seek services or that their referral source identifies as the issue, which requires intervention, usually in the person's own words. It also includes onset, duration, other symptoms noted, progression of the problem, solutions attempted at alleviating the problem, how the person's life has been impacted, and how the person views responsibility for the problem. It can be information from a referral, family or other professional.

"Culture" means the shared patterns of behaviors and interactions, cognitive constructs, and affective understanding learned through a process of socialization. These shared patterns identify the members of a culture group while also distinguishing those of another group. People within a culture usually interpret the meaning of symbols, artifacts, and behaviors in the same or similar ways. Culture includes, but is not limited to: race, ethnicity, religion, spirituality, gender, sexual orientation, language and disabilities.

“Cultural Assessment” means identifying and understanding aspects of an individual's culture and linguistic needs in order to incorporate the information into service planning and service delivery. It is necessary to incorporate cultural considerations into service delivery in order to best understand and address ways in which culture influences an individual's behavioral health issues.

“Discharge” means the termination of treatment obligations and service between the individual and the agency.

“Evidence-Based” practices, principles, and programming are interventions, techniques, and treatment methods that have been tested using scientific methodology and proven to be effective in improving outcomes for a specific population.

“Screening” is a brief process used to determine the identification of current behavioral health or health needs and is typically documented through the use of a standardized instrument. Screening is used to determine the need for further assessment, referral, or immediate intervention services.

**21.190.2          CONTENT OF RECORDS [Eff. 5/1/16]**

- A.      A confidential record shall be maintained for each individual. Records shall be dated and legibly recorded in ink or in electronic format.
  
- B.      Documents shall include, where applicable:
  - 1.      Consent to treatment;
  - 2.      Consent to release confidential information;
  - 3.      Assessments and screenings;
  - 4.      Admission summary;
  - 5.      Service plan;
  - 6.      Re-assessment(s);
  - 7.      Progress notes;
  - 8.      Medication administration or monitoring record;
  - 9.      Physician's orders;
  - 10.     Documentation of on-going services provided by external services providers;
  - 11.     Advance directives;
  - 12.     Acknowledgements and disclosures;
  - 13.     Legal and court paperwork; and,
  - 14.     Discharge summaries.
  
- C.      See specific program areas for additional content of record requirements.

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**21.190.3 ASSESSMENT [Eff. 5/1/16]**

- A. A comprehensive best practices assessment shall be completed as soon as is reasonable upon admission and no later than seven (7) business days of admission into services with the noted exceptions:
1. Acute Treatment Unit: within twenty-four (24) hours of admission.
  2. Withdrawal Management units, inpatient hospitalization: within seventy-two (72) hours of admission.
- B. Assessment shall continue throughout the course of treatment and shall be reviewed and updated when there is a change in the person's level of care or functioning, or, must occur at minimum, every six months.
- C. All methods and procedures used to assess and evaluate an individual shall be developmentally and age appropriate, culturally responsive, and conducted in the individual's preferred language and/or mode of communication.
- D. The assessment shall be documented in the individual record and, at minimum, include the following where information is available and applicable:
1. Identification and demographic data;
  2. Chief complaint/presenting problem;
  3. Mental health history;
  4. Substance use;
  5. Physical and dental health status;
  6. A diagnosis with sufficient supporting criteria and any subsequent changes in diagnosis;
  7. A mental status examination for each individual who is given a diagnosis;
  8. History of involuntary treatment;
  9. Advance directives.
  10. Capacity for self-sufficiency and daily functioning;
  11. Cultural factors that may impact treatment, including age, ethnicity, linguistic/communication needs, gender, sexual orientation, relational roles, spiritual beliefs, socio-economic status, personal values, level of acculturation and/or assimilation, and coping skills;
  12. Education, vocational training, and military service;
  13. Family and social relationships;
  14. Trauma;
  15. Physical/sexual abuse or perpetration and current risk;

16. Legal issues;
17. Issues specific to older adults such as hearing loss, vision loss, strength; mobility and other aging issues;
18. Issues specific to children/adolescents such as growth and development, daily activities, legal guardians and need for family involvement and engagement in the child's treatment;
19. Strengths, abilities, skills, and interests; and,
20. Barriers to treatment.

E. See specific program areas for additional assessment requirements.

**21.190.4 SERVICE PLANNING AND REVIEWS**

**21.190.41 Service Planning Requirements [Eff. 5/1/16]**

- A. An individualized, integrated, comprehensive, written service plan will be:
1. Collaboratively developed between the individual and service provider or treatment team;
  2. Goal focused;
  3. Written in a manner that fosters an individual's highest possible level of independent functioning; and,
  4. Ongoing throughout treatment.
- B. Service planning shall be developed with the individual following an identified assessment(s) and shall apply intervention, treatment, recovery oriented services and continuing care strategies to the degree indicated by the findings of the assessment(s).
- C. An initial service plan shall be formulated to address the immediate needs of the individual within twenty-four (24) hours of assessment.
- D. The service plan shall be developed, by a multidisciplinary team when applicable, as soon as is reasonable after admission and no later than:
1. Acute Treatment Units (ATU): twenty-four (24) hours of admission;
  2. Withdrawal Management: seventy-two (72) hours of admission;
  3. Inpatient Hospitalization: seventy-two (72) hours of admission;
  4. Residential Treatment Facility: ten (10) business days after assessment;
  5. Partial Hospitalization: seven (7) business days after assessment; or,
  6. Outpatient: fourteen (14) business days after assessment.
- E. In addition, services plans shall:
1. Specify goals based on the assessment;

2. Be strength-based, gender appropriate, and individually directed;
  3. Reflect findings of a cultural assessment, to include, but not limited to: gender, sexual orientation, socio-economic status, ethnicity, personal values, level of acculturation and/or assimilation, spirituality, linguistics, age, family systems, interpretation of trauma and coping skills;
  4. Contain specific, measurable, attainable objectives that relate to the goals and have realistic expected date(s) of achievement;
  5. Goals and objectives written in a manner understandable to the individual;
  6. Identify the type, frequency and duration of services;
  7. Be developmentally and/or age appropriate; and,
  8. Include involvement of other identified family and supportive individuals, when appropriate.
- F. All parties (the individual, legal guardian, multidisciplinary team members) who participate in the development of the plan shall sign the plan. The record shall contain documentation whenever a plan is not signed by the individual or participating parties.
- G. There shall be documentation that the individual was offered a copy of the plan.

**21.190.42 Service Plan Revisions and Reviews [Eff. 5/1/16]**

- A. Unless otherwise indicated, reviews and any service plan revisions shall be completed and documented when there is a change in the individuals' level of functioning or service needs and no later than:
1. Acute Treatment Units (ATU) and Withdrawal Management: three (3) calendar days;
  2. Inpatient Hospitalization: every seven (7) calendar days for four (4) weeks; after four (4) weeks: monthly; and, after six (6) months: quarterly;
  3. Residential Treatment Facility: monthly for six (6) months and quarterly after six (6) months;
  4. Partial Hospitalization: every fourteen (14) calendar days;
  5. Opioid Medication Assisted Treatment: every three (3) months; or,
  6. Outpatient: every six (6) months, unless individuals receive medication/psychiatric services only as described in Section 21.190.7.
- B. The service plan review shall include documentation of:
1. Progress made in relation to planned treatment outcomes;
  2. Any changes in the individual's treatment focus; and,
  3. Adjustments to the plan concerning individual lengths of stay as indicated by on-going assessments.

- C. Reviews shall be conducted collaboratively by clinician and individual.
- D. The record shall contain documentation whenever the individual or participating parties do not sign a revised plan.
- E. There shall be documentation that the individual was offered a copy of the plan.

**21.190.5 TREATMENT PROGRESS DOCUMENTATION REQUIREMENTS [Eff. 5/1/16]**

- A. Progress notes are a written chronological record of an individual's progress in relation to planned outcomes of services.
- B. Progress notes shall contain the following information unless otherwise noted in specific service population sections of these rules:
  - 1. Ongoing progress including dates and types of service, adhering to program-specific frequency requirements;
  - 2. A summary of the activity for the session and progress toward specific treatment goals to be completed with minimum frequency of:
    - a. One (1) note per session for outpatient and intensive outpatient,
    - b. Daily for inpatient and intensive residential services,
    - c. Weekly for partial hospitalization and all other levels of residential treatment;
  - 3. The individual's response to treatment approaches and information about progress toward achieving service plan goals and objectives;
  - 4. Changes in the service plan with reasons for such changes;
  - 5. Information regarding support and ancillary services recommended and provided;
  - 6. Any significant change in physical, behavioral, cognitive and functional condition and action taken by staff to address the individual's changing needs; and,
  - 7. Case management notes reflecting the content of each contact, including ancillary and collateral contacts.
- C. Treatment notes shall not include protected health information pertaining to other individuals receiving services.
- D. Treatment entries shall be signed and dated by the author at the time they are written, with at least first initial, last name, degree and or professional credentials. Telephone orders shall be written at the time they are given and authenticated at a later time.

**21.190.6 DISCHARGE PLANNING AND SUMMARIES**

**21.190.61 Discharge Planning Requirements [Eff. 5/1/16]**

- A. Discharge planning begins at the time of admission, is updated during the course of services, and engages the individual and support systems s/he identifies in the planning process.

- B. Discharge policies and procedures shall include criteria outlining the requirements for an individual's discharge from treatment.
- C. Discharge plans shall be concise, complete, and comprehensive to facilitate transition to the next level of care when applicable.
- D. Persons receiving services on a voluntary basis shall be discharged from treatment immediately at their request unless emergency commitments or emergency mental health holds are in effect.
- E. Documentation of discharge information provided to the individual, where applicable, shall include:
  - 1. Medications at discharge including, dosages and instructions for follow-up;
  - 2. Legal status and any other legal restrictions placed upon the individual;
  - 3. Referrals with details; and,
  - 4. Information if the discharge is being made against advice of provider.

**21.190.62 Discharge Summary [Eff. 5/1/16]**

Discharge summaries shall be completed as soon as possible, no later than thirty (30) calendar days after discharge. The agency's policy and procedures shall determine the minimum timeframe for completion. Records shall contain a written discharge summary to include, but not limited to, the following information, where applicable:

- A. Reason for admission;
- B. Reason for discharge;
- C. Primary and significant issues identified during course of services;
- D. Diagnoses;
- E. Summary of services, progress made, and outstanding concerns;
- F. Coordination of care with other service providers;
- G. Advance directives developed or initiated during course of services.
- H. Summary of medications prescribed during treatment, including the individual's responses to medications;
- I. Medications recommended and prescribed at discharge;
- J. Summary of legal status throughout the course of services and at time of discharge;
- K. Documentation of referrals and recommendations for follow up care;
- L. Documentation of the individual's and/or family's response and attitude regarding discharge; and,
- M. Information regarding the death of the individual.

**21.190.7 MEDICATION/PSYCHIATRIC SERVICES ONLY AT MENTAL HEALTH CENTERS AND CLINICS [Eff. 11/1/13]**

- A. A person qualifies to be classified as receiving medication/psychiatric services only when the agency provides a maximum of three (3) services, in addition to services related to medications, within a six (6) month period of time.
- B. At least annually, a licensed behavioral health professional shall complete and document in the clinical record:
  - 1. Clinical rationale supporting a medication/psychiatric services only status;
  - 2. An updated assessment;
  - 3. An updated service plan; and,
  - 4. A Colorado Client Assessment Record (CCAR).

**21.200 CARE AND TREATMENT OF CHILDREN, YOUTH AND FAMILIES**

**21.200.1 BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH**

**21.200.11 Definitions [Eff 5/1/16]**

“Youth” in this section means, under the age of twenty-one (21), unless otherwise noted.

**21.200.12 General Provisions [Eff. 5/1/16]**

In addition to these rules, programs providing behavioral health services to children and adolescents must follow provisions made in Sections 21.110 through 21.190.

Residential child care facilities licensed by the Colorado Department of Human Services, Division of Child Welfare, shall follow Sections 21.120 and 21.200, where applicable.

**21.200.13 Rights of Children and Adolescents [Eff. 5/1/16]**

These provisions shall not apply to any youth admitted to a facility designated under Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness, for behavioral health purposes pursuant to the Children’s Code, Title 19, C.R.S., when there have been judicial proceedings authorizing the placement of the youth into a facility.

- A. In addition to the individual rights in Section 21.280.26 for adults, youth who are fifteen (15) years of age or older, with or without the consent of a parent or legal guardian, have the right to:
  - 1. Consent to receive behavioral health services from an agency or a professional person;
  - 2. Consent to voluntary hospitalization;
  - 3. Object to hospitalization and to have that objection reviewed by the court under the provision of Section 27-65-103, C.R.S.; and
  - 4. Consent to release of information.

- B. Parents or legal guardians shall be contacted without the youth's written consent if:
  - 1. The individual presents as a danger to self or others; or,
  - 2. Essential medical information is necessary for parents or legal guardians to make informed medical decisions on behalf of youth.
- C. Behavioral health facilities must obtain parental or legal guardian consent for youth under fifteen (15) years of age.
- D. Youth who are under the age of fifteen (15) have the right to object to hospitalization and to have a guardian ad litem appointed pursuant to Section 27-65-103, C.R.S.
- E. Appropriate educational programs shall be available for all school age youth who are residents of the designated facility in excess of fourteen (14) calendar days. These educational programs may be provided by either the local school district or by the designated facility. If provided by the designated facility, the educational program shall be approved by the Colorado Department of Education.

**21.200.14 Assessment of Children and Adolescents [Eff. 5/1/16]**

Agencies shall follow Section 21.190.3 and the following:

- A. Assessments must include an evaluation of the family's, or other supportive adult's, social and environmental challenges and strengths that may pertain to the youth's treatment. If family or other supportive adults support needs are identified, this shall be addressed in the service plan.
- B. The assessment must explore how the identified family members, supportive individuals or significant others will be involved in behavioral health services. In the event that any individual's involvement is contraindicated, the clinical rationale must be documented.
- C. An assessment shall address any needs of a youth at least seventeen (17) years of age who is expected to require behavioral health services and supports beyond the age of eighteen (18).

**21.200.15 Service Planning for Children and Adolescents [Eff. 5/1/16]**

Agencies shall follow Section 21.190.4, service planning and reviews, and the following:

- A. The service plan shall be developed in collaboration with the youth's parent or legal guardian and be signed by both. In the event that involvement of the parent or legal guardian is contraindicated, the rationale shall be documented.
- B. A copy of the service plan shall be provided to the individual and parent or legal guardian, unless contraindicated.
- C. The service plan shall include goals and objectives that address family support needs as identified in the assessment.

**21.200.2 LICENSED SUBSTANCE USE DISORDER AGENCIES TREATING YOUTH [Eff. 5/1/16]**

- A. Agencies providing substance use disorder treatment services to youth shall be licensed by the Department to treat youth and comply with Section 21.210.

- B. Agencies shall implement evidence-based screening, assessment instruments, and curricula, designed and developed for youth.
- C. Agencies shall provide recovery-oriented services appropriate for youth, when indicated.
- D. Youth shall be informed that non-compliance with treatment programs to which they are sentenced shall be reported by the agency to referring courts and/or their agents.

**21.200.3 Minor in Possession: Education and Treatment [Eff. 5/1/16]**

For the purposes of this section "Minor in Possession" (MIP) is the legal terminology used for an offense that is issued to individuals age twenty (20) and younger for underage drinking or possession. MIP may result in a revocation of a driver's license, a substance use disorder assessment, and/or alcohol education and treatment classes per Section 18-13-122, C.R.S.

**21.200.31 General Provisions [Eff. 5/1/16]**

- A. Agencies providing MIP services shall comply with Section 21.200.2.
- B. Agencies shall not place a youth with a MIP citation in DUI/DWAI education or therapy groups unless the youth also has a DUI/DWAI offense.
- C. All agency education and treatment staff shall have documented training, supervision and experience in adolescent development and prevention, intervention and treatment approaches.
- D. When possible, minors sixteen (16) years of age and under should be treated in separate groups than those that are provided to individuals seventeen (17) to twenty (20) years old.
- E. Agencies shall conduct ongoing assessment of progress in education and/or treatment level of care to determine if youth are in the appropriate service level.

**21.200.32 Minor in Possession: First Offense Education and Intervention [Eff. 5/1/16]**

- A. MIP education is for youth who have received their first MIP citation and shall be conducted in an outpatient setting.
- B. MIP education shall be at least eight (8) hours, completed over no less than a two (2) day period with no more than four (4) hours of education per day.
- C. Education topics shall include:
  - 1. Current legal consequences for additional MIP citations;
  - 2. Resources or referrals for treatment level services, when indicated;
  - 3. Developmental impact of early onset substance use and subsequent impact on developing brain;
  - 4. Physiological effect of alcohol and other drug use;
  - 5. Refusal skills; and,
  - 6. Avoidance of high risk situations.

- D. For youth seventeen (17) years old and younger, agencies shall include and document a minimum of two (2) hours of parental involvement, unless contraindicated.

**21.200.33 Minor in Possession: Second and Subsequent Offense Treatment [Eff. 5/1/16]**

A. Second Minor in Possession Offense

1. Second offense MIP therapy shall be conducted in an outpatient setting, shall be a minimum of twelve (12) hours in duration over eight (8) weeks, and shall not exceed ninety (90) minute sessions, excluding breaks and administrative procedures.
2. Agencies shall complete an individualized service plan, with each youth in accordance with Sections 21.190.4 and 21.200.15 of these rules.
3. For youth seventeen (17) years old and younger, agencies shall include and document a minimum of four (4) hours of parental involvement, unless contraindicated.

B. Third and Subsequent Minor in Possession Offenses

1. A third MIP results in a Class 2 misdemeanor. Youth shall complete a minimum of twenty (20) hours of substance use disorder treatment over a minimum thirteen (13) week period, as determined by the assessment. Groups shall not exceed ninety (90) minutes in duration.
2. Multiple levels of care shall be offered to meet the needs of the individual and family members, when appropriate.
3. Agencies shall include and document parental involvement, unless contraindicated, throughout the length of treatment.

**21.200.4 CHILD MENTAL HEALTH TREATMENT ACT [Eff. 5/1/16]**

These rules are intended to implement the mental health treatment services defined in the Child Mental Health Treatment Act, Sections 27-67-101 through 27-67-108, C.R.S., subject to available appropriations, to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the Child Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. In addition, the rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by private insurance or Medicaid provided under the Child Mental Health Treatment Act. Appeal procedures for denial of residential and community mental health treatment are established in the rules as well as a dispute resolution process for county departments and mental health agencies.

**21.200.41 Definitions [Eff. 5/1/16]**

“Ability to Pay” means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of community mental health treatment and room and board for a child in residential treatment.

“BHO” means the Behavioral Health Organization responsible for implementing the Medicaid mental health capitation program through contract with the Colorado Department of Health Care Policy and Financing.

“Care Management” means arranging for continuity of care and coordinating the array of service necessary for treating the child; communicating with responsible individuals, and providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being made; and the authority to rescind authorization for any treatment services with proper notice.

“Child at Risk of Out-of-Home Placement” means a child between the ages of zero (0) and his/her eighteenth (18th) birthday who, although not otherwise categorically eligible for Medicaid, meets the following criteria:

- A. Has been diagnosed as a person with a mental illness, as defined in Section 27-65-102(14), C.R.S.;
- B. Requires a level of care that is provided in a residential child care facility pursuant to Section 25.5-5-306, C.R.S., or that is provided through in-home or community-based programs and who, without such care, is at risk of out of home placement;
- C. If determined to be in need of placement in a residential child care facility, is determined to be eligible for Supplemental Security Income; and,
- D. For whom it is inappropriate or unwarranted to file an action in dependency or neglect pursuant to Article 3 of Title 19, C.R.S.

“Children who are categorically Medicaid eligible” means a child between the ages of zero (0) and his/her eighteenth (18th) birthday who, with a covered mental health diagnosis, is eligible for services through the Capitated Single Entry Point System for Mental Health Services Program described in Section 25.5-5-411, C.R.S.

“Community-Based Services” includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment.

“Community Mental Health Center, as defined in Section 27-66-101, C.R.S., means either a physical facility or a group of services under unified administration or affiliated with one another, and includes at least the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the community mental health center or group so situated:

- A. Inpatient services;
- B. Outpatient services;
- C. Partial hospitalization;
- D. Emergency services; and,
- E. Consultative and educational services.

“Cost of Care” includes residential and community-based treatment not covered by private insurance or Medicaid, and room and board. “County Department” means the county, or district, department of human/social services.

“Face to Face”, for the purpose of this Section 21.200.4, means that the child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used.

“Licensed Mental Health Professional” means a psychologist licensed pursuant to Section 12-43-301, et seq., C.R.S., a psychiatrist licensed pursuant to Section 12-36-101, et seq., C.R.S., a clinical social worker licensed pursuant to Section 12-43-401, et seq., C.R.S., a marriage and family therapist licensed pursuant to Section 12-43-501, et seq., a professional counselor licensed pursuant to Section 12-43-601, et seq., C.R.S., or a social worker licensed by pursuant to Section 12-43-401, et seq., C.R.S., that is supervised by a licensed clinical social worker.

“Mental Health Agency” means the community mental health center serving children in a particular geographic area or the Behavioral Health Organization, serving children in a particular geographic area who are receiving Medicaid, under contract with the Colorado Department of Health Care Policy and Financing.

“Plan of Care” is a Department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of Supplemental Security Income payable to the residential treatment facility or other provider, and sliding scale fees payable to the contractor, if applicable.

“Resident” means a child receiving residential mental health treatment under the Child Mental Health Treatment Act.

“Residential Treatment” means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to Section 26-6-102(8), C.R.S., which has been approved by the Department to provide mental health treatment.

“Responsible Persons” means parent(s) or legal guardian(s) of a minor.

#### **21.200.42 Child Mental Health Treatment Act Program Description [Eff. 5/1/16]**

The Child Mental Health Treatment Act allows parents or guardians to apply to a mental health agency on behalf of their minor child for mental health treatment services whether the child is categorically eligible for Medicaid under the capitated mental health system, or whether the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41.

- A. For children who are not categorically eligible at the time services are requested, the community mental health center is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community-based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child’s and family’s needs. A dependency or neglect action pursuant to Article 3 of Title 19, C.R.S., shall not be required in order to allow a family access to residential or community-based mental health treatment services for a child.
- B. For children who are categorically eligible for Medicaid as defined in Section 21.200.41, the BHO is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child’s and family’s needs.
- C. The Child Mental Health Treatment Act, Sections 27-67-101 through 27-67-108, C.R.S., provides appeal processes for parents or guardians when services are denied, and to resolve disputes between mental health agencies and county departments.
- D. The Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by private insurance, Medicaid, or the family’s share.

**21.200.43 Application for Mental Health Treatment for Children [Eff. 11/1/13]**

- A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment.
- B. The mental health agency will evaluate the child and clinically assess the child's need for mental health services. When warranted, treatment services will be provided as may be necessary and in the best interests of the child and the child's family.
- C. Subject to available appropriations, the mental health agency shall be responsible for the provision of care management and necessary treatment services, including any community-based mental health treatment, other family preservation services, residential treatment, or any pre- or post-residential services that may be appropriate for the child's or family's needs.
- D. A face to face clinical assessment and decision regarding requests for treatment shall be performed by the mental health agency within the following time periods after a request for mental health treatment has been made by a responsible person.
  - 1. Emergency situation, defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situation evaluations shall be completed within six (6) business hours of the initial assessment request.
  - 2. Urgent situation, defined as a condition that appears to, if not addressed within twenty-four (24) hours, be likely to escalate to an emergency situation. Urgent situation evaluations shall be completed within twenty-four (24) hours, one (1) business day, of the initial assessment request.
  - 3. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request.
  - 4. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect.
- E. The mental health agency decision shall be communicated verbally and in writing to the responsible person within the time allowed for the completion of the evaluation. Verbal notice shall be face to face with the responsible person when possible.

The written decision shall contain notice of the applicable criteria for mental health treatment, the factual basis for the decision, the appeals procedures, and a statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.

**21.200.44 Process of Determining Ability to Pay and Adjusted Charge for Treatment Services Provided to Children at Risk of Out-of-Home Placement [Eff. 5/1/16]**

- A. The community mental health center shall determine the cost of care for children in this program. Insurance and other benefits shall be applied first to the cost of care. Medicaid is the payor of last resort and will be provided, if the child is eligible, if other insurance coverage is not available. Insurance and other benefits for any resident shall be billed at the full cost of care. A responsible person(s) who fails to cooperate in making existing insurance and other benefits available for payment will nevertheless be considered as having benefits available for payment.

- B. The responsible person(s)' ability to pay for residential treatment shall be calculated using material based on the "Colorado Child Support Guideline" and the "Schedule of Basic Child Support Obligations," as found in Section 14-10-115, C.R.S., and the Department's Child Support Enforcement rules (9 CCR 2504-1).
- C. The fee for community-based services shall be based on the income of the "responsible persons" defined in Section 21.200.41, using the "Uniform Method of Determining Ability to Pay" in Section 21.800, et seq.  

The cost of home and community based services shall not exceed fifty percent (50%) of that which would have been charged to the responsible persons for residential treatment.
- D. The treating facility and/or provider may reserve the right to take any necessary action regarding delinquent payments by the responsible person(s).
- E. The responsible person(s) shall be the balance of the cost of care after insurance and other benefits have been deducted, or the ability to pay, whichever is less. If the responsible person(s) does not cooperate in making insurance and other benefits available, the responsible person(s) will be billed for the amount equal to the dollar value of the insurance or benefits in addition to the lesser of the balance of the cost of care or the ability to pay. If the dollar value of insurance and other benefits cannot be determined, the legally responsible person(s) will be billed the full cost of care.
- F. The responsible person(s) must sign a financial agreement indicating an understanding of their financial responsibilities as described in A-E, above, in order to be eligible for funding through the Child Mental Health Treatment Act.
- G. Within ten (10) business days after the child's admission to the residential treatment facility, the responsible person must apply for Supplemental Security Income (SSI) on behalf of a child at risk of out-of-home placement approved for treatment under the Child Mental Health Treatment Act.
- H. The responsible person must pay the monthly parental fee to the facility.

**21.200.45 Process of Determining Funding for Children who are Categorically Eligible for Medicaid [Eff. 5/1/16]**

As outlined in Section 8.212 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10), costs and services are managed by the corresponding behavioral health organization for children who are categorically eligible for Medicaid at the time treatment is requested.

**21.200.46 Dispute Resolution for Denial of Mental Health Treatment for Children at Risk of Out-of-Home Placement [Eff. 5/1/16]**

- A. Except as provided below, the community mental health center shall follow the formalized appeal process that the agency has established pursuant to the grievance requirements in Section 21.180 if the child is at risk of out-of-home placement, as defined in Section 21.200.41.

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- B. If the responsible person(s) requests an appeal of a denial of treatment or a recommendation that a child be discharged from services, either in writing or verbally within fifteen (15) business days of notice of action, the mental health agency shall have two (2) business days within which to complete the internal appeal review process and communicate a decision to the responsible person(s) verbally in person when possible and in writing. Said notice shall contain the information required in Section 21.200.43, E, along with the process for clinical review in Section 21.200.46, C-E, below. If the community mental health center requires more than two (2) business days to complete its internal review and the responsible person(s) is in agreement, then the community mental health center may take up to but no more than five (5) business days to complete the review. If the responsible party is not agreeable, the two (2) business day timeline discussed above will remain in effect.
- C. Within five (5) business days after the community mental health center's final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the Department, who is an independent professional person as that term is defined in Section 27-65-102(11), C.R.S., to review the action of the community mental health center. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the Director of the Office of Behavioral Health or the consumer and Office's family affairs specialist.
- D. Unless waived by the responsible person(s), said clinical review shall include:
1. A review of the community mental health center's denial of services;
  2. A face to face evaluation of the child, so long as the responsible person(s) arranges transportation of the child for the evaluation; and,
  3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below.
- E. Within three (3) working days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), Department and the community mental health center. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community based treatment to be necessary, the mental health agency shall provide treatment to the child within twenty four (24) hours of said decision. If residential treatment is not available within twenty four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home.
- F. If the professional person requires more than three (3) working days to complete the face to face evaluation, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) working days.
- G. The Department review shall constitute final agency action for non-Medicaid eligible children.

**21.200.47 Dispute Resolution Process for Denial of Mental Health Treatment for Children Who Are Categorically Eligible for Medicaid [Eff. 5/1/16]**

- A. For children who are categorically eligible for Medicaid, the responsible person(s) may request an appeal of a denial of treatment pursuant to the Medicaid "recipient appeals" process found at Section 8.057 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10).
- B. For children who are categorically eligible for Medicaid, the responsible person(s) may request a clinical review by the Department as outlined in Section 21.200.46.

**21.200.48 Dispute Resolution Process between County Departments and Mental Health Agencies [Eff. 5/1/16]**

- A. If a dispute exists between a mental health agency and a county department of human/social services regarding whether mental health services should be provided under the Child Mental Health Treatment Act or by the county department, one or both may request the Colorado Department of Human Services, Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado Department of Human Services, Division of Child Welfare, the Colorado Department of Human Services, Office of Behavioral Health, an independent community mental health center, an independent county department of human/social services and, when applicable, the Colorado Department of Health Care Policy and Financing to provide dispute resolution.
- B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing that a dispute exists.
- C. The written request for dispute resolution shall include, at a minimum, the following information:
  - 1. The county department and mental health agency involved in the dispute, including a contact person at each;
  - 2. The child's name, age, and address;
  - 3. The responsible person(s) address, phone number, and e-mail address;
  - 4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment;
  - 5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child;
  - 6. Information about the child's mental health status pertaining to the dispute; and,
  - 7. The responsible person(s) perspective on the matter, if known.
- D. Within ten (10) calendar days of receiving the dispute resolution request, the Department shall convene a review panel in order for each side to present their position.
- E. The Department shall provide notice to both agencies that the Department will resolve the dispute.
- F. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel.

- G. After both agencies present their positions, and other parties present as appropriate, the review panel shall have five (5) working days to issue its determination in writing to the disputing agencies. The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.

**21.200.49 Responsibilities**

**21.200.491 Responsibilities of Community Mental Health Centers [Eff. 5/1/16]**

Subject to the availability of state appropriations, the community mental health center shall provide Child Mental Health Treatment Act services to youth who are eligible as defined in Sections 20.100 and 20.200.

- A. Child Mental Health Treatment Act services include, but are not limited to:
1. Clinical behavioral health assessments completed by a licensed mental health professional;
  2. Community based services;
  3. Care management services;
  4. Coordination of residential treatment services; and,
  5. Non-residential mental health transition services for youth.
- B. The community mental health center shall provide to the Department necessary Child Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format.
- C. The community mental health center shall submit data to the Department as required per Section 27-67-105, C.R.S.
- D. The community mental health center shall provide or coordinate treatment services in collaboration with youth and families, and community based and residential care providers.
- E. The community mental health center shall determine the fee for the responsible person(s) and submit the financial agreement to the Department once signed by the responsible person(s) prior to state approval.
- F. If a child has been determined eligible under the Child Mental Health Treatment Act, the community mental health center shall submit a plan of care for approval to the Department prior to providing services. If necessary services are not immediately available, the community [mental] health center shall submit an alternative plan of care and provide interim services as appropriate.
- G. The community mental health center shall maintain a comprehensive clinical record for each child receiving services through Child Mental Health Treatment Act funding consistent with the Department's site review protocol. Such records shall be made available for review by the Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third party providers to assure that adequate progress is achieved, and may reference the state plan of care and the provider's clinical service plan.

**21.200.492 Responsibilities of the Department [Eff. 5/1/16]**

The Department shall be responsible for administering and regulating the provisions of the Child Mental Health Treatment Act. The responsibilities of the Department include:

- A. Ensuring the Child Mental Health Treatment Act is implemented statewide;
- B. Reviewing requests for funding and making recommendations regarding approval of service delivery related to plans of care for children who are at risk of out-of-home placement as defined in Section 20.200.41;
- C. The provision of technical assistance to community mental health centers, residential treatment providers, families and advocacy organizations regarding the technical and financial aspects of the Child Mental Health Treatment Act;
- D. Oversight and monitoring of service delivery for children receiving Child Mental Health Treatment Act funded services;
- E. Development and maintenance of dispute resolution processes;
- F. Management of the fiscal aspects of the Child Mental Health Treatment Act program; and,
- G. Data Collection and reporting.

**21.200.5 FAMILY ADVOCACY MENTAL HEALTH JUVENILE JUSTICE PROGRAMS [Eff. 5/1/16]**

These rules and standards implement the Integrated System of Care Family Advocacy Programs for Mental Health Juvenile Justice Populations defined in Section 27-69-101, et seq., C.R.S. The rules and standards do not apply to other forms of family advocacy provided by persons or organizations, nor do they place any requirements or assume authority over such persons or organizations. Families of youth with mental health and co-occurring disorders who are in, or at-risk of becoming involved with, the juvenile justice system, may choose any form of advocacy and support that best meets their needs and are not limited to utilizing entities approved under these rules and standards.

In order to be eligible for state funding for a family advocacy program as described in Section 27-69-101, et seq., C.R.S., and these rules, an entity must be approved by the Department according to the rules described herein. Such funding is contingent on available appropriations.

**21.200.51 Definitions [Eff. 5/1/16]**

“At-risk of involvement with the juvenile justice system” means a youth who has come into contact with law enforcement due to a suspected offense or otherwise exhibits behaviors that will likely result in juvenile justice involvement.

“Family advocacy organization” means an entity governed by individuals who have parented, are parenting, or have legal responsibility for a child or youth with a mental health or co-occurring disorder.

“Family member” means individual who has parented, is parenting, or has legal responsibility for a youth with a mental health or co-occurring disorder.

“Involved in the juvenile justice system” means a youth who has committed a delinquent act as defined at Section 19-1-103(36), C.R.S.

“Partnership” means a relationship between a family advocacy organization and another entity whereby the family advocacy organization works directly with another entity for oversight and management of the family advocate or family systems navigator and family advocacy demonstration program, and the family advocacy organization employs, supervises, mentors, and provides training to the family advocate or family systems navigator.

“System of care” means a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

“Technical assistance and coordination” means linking with resources for the purpose of developing or strengthening a family advocacy program.

“Transition services” include, but are not limited to, assisting a youth and family in accessing services and supports necessary for the youth to become a successful adult; developing life skills necessary to function in the community; returning to home, community, or school from an out-of-home placement.

“Youth” for the purposes of this section means an individual whose age falls within the jurisdiction of the juvenile justice system and is older than ten (10) years of age and under eighteen (18) years of age (see Section 19-1-103 (18) for definition of “child”). A young person receiving family advocacy services may continue to do so up to twenty one (21) years of age if enrolled in the program between the ages of ten (10) and eighteen (18).

**21.200.52 Intent to Become a Family Advocacy Program [Eff. 5/1/16]**

- A. A partnership will indicate its intent to become a family advocacy program by completing the family advocacy program application and submitting it to the Department.
- B. The partnership will follow all requirements of Section 27-69-101 through 27-69-105, C.R.S. and these corresponding rules.
- C. The Department will acknowledge in writing receipt of the letter of application and state which documents, if any, are required to be forwarded to the Department for review.
- D. A partnership may request the Department to facilitate technical assistance and coordination, as described in Section 21.200.53, needed to complete its application.

**21.200.53 Program Standards [Eff. 5/1/16]**

- A. Family advocacy programs will consist of a partnership between a family advocacy organization providing family advocacy and the system of care, whereby the family advocacy organization works with other entities to enable youth and families to access necessary services and supports. The family advocacy organization employs or otherwise utilizes, supervises, mentors, and provides training to the family advocate or family systems navigator. A community agency may employ or otherwise utilize, supervise, mentor, and provide training to the family advocate or family systems navigator if there is a written agreement with a family advocacy organization describing how this will occur.
- B. The purpose of a family advocacy program is to provide support to families of youth with mental health and co-occurring disorders who are in, or at-risk of becoming involved with, the juvenile justice system.

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- C. The support provided to families and youth will include early intervention, navigation, crisis response, integrated planning, transition services, and diversion. These supports will be provided in collaboration with community agencies with specific expertise in the area.
- D. Family support will be provided by a family advocate or a family systems navigator as outlined in Section 27-69-102(5) and (5.5), C.R.S. The requirements for these roles are as follows:
1. Family advocate:
    - a. Training in assisting families in accessing and receiving services and supports, and the system of care philosophy;
    - b. Experience as a family member of a child or adolescent with a mental health or co-occurring disorder; and,
    - c. Experience in working with multiple youth-serving agencies and providers.
  2. Family systems navigator:
    - a. Training in assisting families in accessing and receiving services and supports, and the system of care philosophy;
    - b. Skills, experience, and knowledge to work with children and youth with mental health or co-occurring disorders; and,
    - c. Worked with multiple youth-serving agencies and providers.
- E. A family advocacy program will coordinate its efforts with key service providers to ensure that support provided by family advocates and family systems navigators is integrated with services provided by community agencies. Where applicable, this coordination will include the local Interagency Oversight Group of the Collaborative Management Program, described in Section 24-1.9-102, C.R.S. and local juvenile services planning committee described in Section 19-2-211, C.R.S.
- F. A family advocate or family systems navigator will receive training commensurate with their duties and responsibilities. The training will include content on behavioral and co-occurring conditions, working with youth-serving systems, ethics, confidentiality and HIPAA, system of care, working with families, meeting facilitation, prevention and intervention, and documentation and service planning.
- G. A family advocacy program will provide education to the relevant agencies in the system of care, describing the roles and responsibilities of family advocates and family systems navigators, and the ways in which these positions can benefit youth, families, and agency staff members.
- H. A family advocacy program will ensure that adequate resources are available for program operations and evaluation as described in Section 21.200.54.
- I. Family advocates or family systems navigators will receive supervision commensurate with the needs of the youth and families. Family advocates or family systems navigators working in community agencies will receive supervision consistent with the policies and procedures of the host agency.
- J. Any person providing supervision to a family advocate or family systems navigator will have demonstrable knowledge about Section 27-69-101, et seq., C.R.S., these rules, and the role and function of a family advocacy program.

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- K. Family advocacy programs will have policies and procedures concerning the work of family advocates and family systems navigators that address:
1. Experience and hiring requirements, including a name search through the Colorado Bureau of Investigation, and a check of child abuse and neglect records and reports in the Trails database maintained by the Colorado Department of Human Services;
  2. The program's standards of practice and code of ethics;
  3. Training related to providing support to families of youth with a mental health or co-occurring condition;
  4. A description of each aspect of the program, including related staff roles and responsibilities;
  5. The handling of grievances and complaints;
  6. Confidentiality, the Health Insurance Portability and Accountability Act (HIPAA), and 42 CFR Part 2; no amendments or later editions are incorporated. A copy is available for inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library; and,
  7. Methods for recording information concerning each family receiving support including demographics, assessment results, needs and strengths, goals and objectives, support provided, and other information as needed.
- L. The services and supports provided by a family advocacy program will include, but not be limited to, those outlined in Section 27-69-104(3), C.R.S., and the following:
1. An assessment of the needs and strengths of the youth and family;
  2. Assisting families with significant transitions in the youth's life;
  3. Coordination with the local community mental health center and other behavioral health service, and;
  4. Culturally and linguistically appropriate and responsive services including bilingual family advocates and/or family systems navigators, and/or access to translation services for families when necessary.

**21.200.54 Data Reporting [Eff. 5/1/16]**

- A. Family advocacy programs will collect and report data to the Department. This is necessary for the program and the Department to determine its effectiveness and what, if any, changes are necessary to improve outcomes for youth and families. The results of any data analysis conducted by the Department will be shared with the respective family advocacy program.
- B. The data collected and reported to the Department shall include the following:
1. Types of services and support the youth and families received prior to and during involvement in the family advocacy program;
  2. Outcomes of services and supports provided during the youth and family's involvement in the family advocacy program;

3. Indicators of the youth and family's satisfaction with support provided by the family advocate or family systems navigator;
  4. Indicators of the effectiveness of the family advocate or family systems navigator;
  5. Indicators of change in the system of care, e.g., interagency agreements, service access and utilization, leadership development among youth and families; and shared resources;
  6. Costs of services provided; and,
  7. Types of transition services provided.
- C. Data will be submitted to the Department in an established and standardized format.

**21.200.55 Technical Assistance and Coordination [Eff. 5/1/16]**

- A. The Department will facilitate the provision of technical assistance and coordination for the purpose of developing or strengthening a family advocacy program.
- B. Technical assistance may include linking with written materials, family organizations, and phone consultation.
- C. Technical assistance provided by organizations other than the Department may require a fee paid to that organization.
- D. Interested entities will request technical assistance by contacting the Department verbally or in writing.

**21.210 AGENCIES LICENSED TO PROVIDE SUBSTANCE USE DISORDER SERVICES [Eff. 11/1/13]**

In addition to the rules provided in Sections 21.000 through 21.190, all agencies licensed to provide substance use disorder services shall comply with the following rule Sections 21.210.1 through 21.210.59.

**21.210.1 AGENCY STAFF QUALIFICATIONS AND TRAINING [Eff. 5/1/16]**

- A. Qualifications referred to in this section, including education, professional credentials, training and supervision, and work experience shall be in accordance with Addiction Counselor Certification and Licensure Standards (Section 21.330).
- B. At least fifty percent (50%) of all treatment staff in substance use disorder programs within each licensed site, excluding non-hospital residential withdrawal management, shall be certified as a Certified Addiction Counselor II (CAC II), Certified Addiction Counselor III (CAC III) or Licensed Addiction Counselor (LAC).
- C. Counselors-in-training or Certified Addiction Counselor I (CAC I) shall not independently counsel, sign clinical documentation or carry out other duties relegated solely to Certified Addiction Counselor II, Certified Addiction Counselor III or Licensed Addiction Counselors. The Counselor-in-training or CAC I must have all clinical documentation reviewed and co-signed by their clinical supervisor. Counselors-in-training and CAC I's shall not comprise more than twenty-five percent (25%) of total treatment staff.

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- D. All staff who are providing psychotherapy services as defined in the Colorado Mental Health Practice Act (Section 12-43-201(9), C.R.S.) must be regulated by the Colorado Department of Regulatory Agencies (DORA), either by credentialing as a CAC I, CAC II OR CAC III or becoming licensed as a mental health professional, including Licensed Addiction Counselor, or by registering in the registered psychotherapist database with DORA. Addiction counselor certifications and licenses shall be current and in good standing.
- E. Treatment staff licensed as behavioral healthcare practitioners in Colorado shall meet one of the following criteria:
1. Licensed physicians who are also:
    - a. Certified in addiction medicine by the American Society of Addiction Medicine (ASAM); or,
    - b. Certified Addiction Counselor (CAC) II or III, or Licensed Addiction Counselor by the Colorado Department of Regulatory Agencies (DORA), Division of Professions and Occupations; or,
    - c. Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC; or,
    - d. Certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN).
  2. Licensed addiction counselors (LAC)
  3. Licensed behavioral health non-physician practitioners are any of the following:
    - a. Psychologist
    - b. Nurse Practitioner
    - c. Licensed Clinical Social Worker (LCSW)
    - d. Licensed Marriage and Family Therapist (LMFT)
    - e. Licensed Professional Counselor (LPC)
- F. All agencies shall provide and document initial training in methods of preventing and controlling infectious diseases and in universal precautions providing protection from possible infection when handling blood and other body fluids. Annual refresher training, including updates, shall be provided and documented.
- G. Staff collecting samples for drug or alcohol testing shall be knowledgeable of collection, handling, recording and storing procedures assuring sample viability for evidentiary and therapeutic purposes.
- H. Agencies administering and/or monitoring individual medications shall maintain at least one staff person per shift who is currently qualified by certification and/or training to perform those functions in accordance with applicable Department rules and state and federal regulations.
- I. Agencies shall document that at least one residential treatment staff person per shift is currently certified in cardiopulmonary resuscitation and basic First Aid.

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**21.210.2 CONTENT OF RECORDS [Eff. 5/1/16]**

In addition to 21.190.2, agencies licensed to provide substance use disorder services shall maintain individual records to include:

- A. Individual acknowledgments of:
  - 1. 42 CFR Part 2 Federal Confidentiality Regulations;
  - 2. HIPAA Privacy Rights;
  - 3. Individual rights;
  - 4. Mandatory disclosure statement;
  - 5. Chargeable fees and collection procedures; and,
  - 6. Awareness of agency emergency procedures.
- B. The out-of state offender questionnaire shall be completed and in all clinical records.
- C. Personal belongings inventories, when applicable.
- D. Court documents, when applicable.
- E. Records of required communication with referral sources such as court, probation, child welfare, and parole, when applicable.
- F. Drug and alcohol testing and monitoring results, when applicable.

**21.210.3 COUNSELOR AND INDIVIDUALS RECEIVING SERVICES' SIGNATURES [Eff. 11/1/13]**

- A. Counselor signatures shall be required on the following treatment documents:
  - 1. Screenings;
  - 2. Assessments;
  - 3. Admission summaries;
  - 4. Service plans;
  - 5. Service plan reviews;
  - 6. Treatment notes;
  - 7. Discharge summaries.
- B. Credentialed counselors who counsel independently shall sign treatment documents with at least first initial, last name, and Colorado addiction counselor credential, other professional credential, or academic degree.
- C. Counselors not credentialed may sign treatment documents if countersigned by supervising credentialed counselors.

- D. Signature stamps shall be permissible in lieu of written signatures if initialed by the counselors whose signatures they represent. Electronic signatures shall be permissible for computerized individual records.
- E. Agencies shall require persons receiving services, or guardians, to sign service plans, service plan reviews, and revisions, consents, acknowledgments, and other documents needing individual authorization.

**21.210.4 PROVISION OF SERVICES**

**21.210.41 Admission Criteria [Eff. 11/1/13]**

- A. The following shall not be the sole reason for treatment ineligibility:
  - 1. Relapse;
  - 2. Leaving previous treatment against advice;
  - 3. Pregnancy;
  - 4. Intravenous drug use; or,
  - 5. Involuntary commitment.
- B. Restrictions, priorities, or special admission criteria shall be applied equally to all prospective persons seeking services.

**21.210.42 Screening [Eff. 5/1/16]**

- A. Agencies shall screen all female individuals of child bearing age seeking or being referred to substance use disorder treatment for pregnancy.
- B. At admission individuals shall be screened for past and present risk factors associated with substance use disorders that are associated with:
  - 1. Pregnancy complications, including risks to the health of the pregnant woman and fetus;
  - 2. Acquiring and transmitting Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Tuberculosis (TB), Hepatitis A, B, or C, and other infectious diseases; and,
  - 3. If clinically indicated by the presence of continuing risk factors, screening shall be conducted at a minimum on a quarterly basis.
- C. Individuals shall be apprised of risk factors associated with acquiring and transmitting HIV/AIDS, TB, Hepatitis A, B, C, and other infectious diseases. Appropriate testing and pre and post-test counseling shall be offered on-site or through referral.
- D. Criminal justice system referrals for substance use related offenses, such as DUI/DWAI, BUI, FUI, and/or controlled substance violations, may be exempt from further substance use disorder screening if previously assessed, or evaluated. Supporting documentation from the referring agency shall be present in the individual record.

- E. Adults shall be screened for past and present criminal charges in any state. Persons with out-of-state charges must be registered by the licensed agency with the interstate compact office in accordance with Title 17, Article 27.1, Section 101, et seq., C.R.S.

**21.210.43 LEVEL OF CARE [Eff. 5/1/16]**

- A. Agencies shall use the American Society of Addiction Medicine patient placement criteria (the ASAM criteria, American Society of Addiction Medicine, Third Edition, 2013) as a guide for assessing and placing individuals in the appropriate level of care. No amendments or later editions are incorporated. A copy is available for inspection during regular business hours at the Colorado Department of Human Services, Office of Behavioral Health, Director of Community Programs, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library.
- B. All levels of care shall give special consideration to the individuals' identified medical and psychiatric needs in planning treatment.
- C. Different levels of care shall offer a range of treatment approaches and support services based on individual readiness to change and focus on identified substance use disorder education and treatment needs. Treatment approaches and support services may include:
1. Group and individual therapy and education;
  2. Relapse prevention;
  3. Building support systems;
  4. Developing coping skills;
  5. Education on substance use disorders;
  6. Vocational counseling;
  7. Life skills training;
  8. Self-help groups; and,
  9. Milieu therapy.

**21.210.44 General Provisions [Eff. 5/1/16]**

- A. Agencies shall document that counselors are appropriately credentialed and qualified to provide treatment services in the levels of care described in this section and the individual populations they serve.
- B. Level I education groups shall not regularly exceed twenty (20) people.
- C. Therapeutic groups and level II therapeutic education groups shall not regularly exceed twelve (12) people.
- D. Outpatient licensed sites shall make emergency services accessible during non-business hours to individuals receiving services by providing pager or emergency room contact information on voice mail or through voice messaging services, twenty-four (24) hours per day, seven (7) days per week. Residential sites shall provide for emergency medical services available to clients twenty four (24) hours per day, seven (7) days per week.

- E. Sliding fee scales shall be applied equally to all prospective persons seeking services.
- F. Agencies shall be responsible for monitoring and routinely reporting to referring courts and the criminal justice system the individual's progress within treatment, including any ancillary services.

**21.210.5 LEVELS OF CARE SPECIFIC REQUIREMENTS**

**21.210.51 ASAM Level 1 (Outpatient Services, SOA-R Level 3 and 4a) [Eff. 5/1/16]**

- A. Outpatient services shall generally be intended for individuals who may or may not have supportive resources during the course of treatment in the form of family, friends, employment or housing but are assessed as not appropriate for more intensive levels of treatment. Traditional outpatient treatment may also be a transition from more intensive treatment settings.
- B. Outpatient services shall be conducted with a frequency of nine (9) or less substance use disorder education/treatment contact hours per week for adults, and six (6) or less substance use disorder education/treatment contact hours per week for youth.
- C. Minimum frequency of treatment contact shall be one time per thirty (30) consecutive calendar days.
- D. ASAM Level 1 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.

**21.210.52 ASAM level 2.1 (Intensive Outpatient Services, SOA-R Level 4b) [Eff. 5/1/16]**

- A. Intensive outpatient services shall generally be intended for individuals who require a more structured substance use disorder outpatient treatment experience than can be received from traditional outpatient treatment. Individuals may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Intensive outpatient treatment may reflect an increase in treatment intensity, such as outpatient to intensive outpatient, or a decrease in treatment intensity, such as residential to intensive outpatient treatment.
- B. Intensive outpatient services shall be conducted with a minimum frequency of nine (9) treatment contact hours per week for adults and a minimum frequency of six (6) treatment contact hours per week for youth.
- C. ASAM Level 2 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.

**21.210.53 ASAM Level 2.5 (Partial Hospitalization Services) [Eff. 5/1/16]**

- A. Partial hospitalization shall generally be intended for individuals who require more structured treatment for substance use disorders than can be provided by intensive outpatient treatment, but are not assessed as needing treatment in a residential setting. Individuals may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Partial hospitalization may be a transition to or from more intensive residential settings.
- B. Partial Hospitalization shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week.

- C. ASAM Level 2 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.

**21.210.54 ASAM Level 3.1 (Clinically Managed Low-Intensity Residential Services) [Eff. 5/1/16]**

- A. This level of treatment shall generally be intended for individuals who are transitioning to higher-intensity or lower-intensity levels of care and/or are reintegrating with the community, and whose history of chronic substance use disorders, lack of functional and supportive living situations, possible unemployment, levels of social or psychological dysfunction and lack of housing necessitate low-intensity residential treatment.
- B. Clinically managed low-intensity residential services shall be conducted with a minimum frequency of five (5) hours of planned clinical treatment activities per week.
- C. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours, per agency site.
- D. Residential facilities delivering ASAM Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.

**21.210.55 ASAM Level 3.2-WM (Clinically Managed Residential Withdrawal Management) [Eff. 5/1/16]**

- A. A non-hospital (non-medical) residential withdrawal management unit is an organized service that may be delivered by trained staff, who provide twenty four (24) hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal.
- B. Individual to staff ratios shall not exceed ten to one (10:1); and,
1. Procedures for responding to periods of high client-traffic and/or emergency situations shall be conspicuously posted.
  2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more consumers are present.
- C. This level provides care for individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe to require twenty four (24) hour structure and support. However the full resources of a Level 3.7-WM medically monitored inpatient withdrawal management service are not necessary.
- D. This level is staffed to supervise self-administered medications for the management of withdrawal. All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care.

**21.210.56 ASAM LEVEL 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services) [Eff. 5/1/16]**

- A. Frequently referred to as extended or long-term care, this level of care provides a structured recovery environment in combination with high-intensity clinical services to support recovery from substance-related disorders.

- B. The functional deficits seen in individuals who are appropriate for this level of care are primarily cognitive and can be either temporary or permanent.
- C. Some individuals have such severe deficits in interpersonal and coping skills that the treatment process is one of “habilitation” rather than “rehabilitation”.
- D. Services may be provided in a deliberately repetitive fashion to address the special cognitive needs of individuals for whom this level of care is considered a medical necessity.
- E. Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community.
- F. Clinically managed population-specific high-intensity Residential Services shall be conducted with a minimum frequency of nine (9) hours of planned clinical treatment activities per week.
- G. A nursing home is widely identified as an example of this level of care.
- H. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours, per agency site.
- I. Residential facilities delivering ASAM Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.

**21.210.57 ASAM Level 3.5 (Clinically Managed High-Intensity Residential Services, SOA-R Level 4d) [Eff. 5/1/16]**

- A. Individuals who are appropriately placed in this level of care typically have multiple deficits, which may include substance-related disorders and criminal activity.
- B. Such individuals generally can be characterized as having chaotic, non-supportive and often abusive interpersonal relationships; extensive treatment or criminal justice histories; chronic substance use disorders; limited work histories and educational experiences; and antisocial value systems.
- C. Standard rehabilitation methods are inadequate to treat these individuals effectively. Effective treatment approaches are primarily habilitative in focus, addressing the individual’s educational and vocational deficits, as well as his or her socially dysfunctional behavior.
- D. This level of care may represent a step-down from Level 3.7 and the therapeutic community is also identified as an example of this level of care.
- E. Clinically Managed High-Intensity Residential Services shall be a minimum frequency of five (5) hours of planned clinical treatment activities per week.
- F. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours, per agency site.
- G. Residential facilities delivering ASAM Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.

**21.210.58 ASAM Level 3.7 (Medically Monitored Intensive Inpatient Services, SOA-R Level 4c) [Eff. 5/1/16]**

- A. Medically monitored treatment shall generally be intended for individuals with significant substance use disorders who may also have extensive criminal and treatment histories, treatment failures in less intensive settings, psychological problems and impaired functioning meriting short-term, high-intensity residential treatment that may include a community re-entry phase.
- B. Medically monitored intensive residential treatment shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week.
- C. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours per agency site.
- D. Residential facilities delivering ASAM Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.

**21.210.59 ASAM Level 3.7-WM (Medically Monitored Inpatient Withdrawal Management) [Eff. 5/1/16]**

This level of care is an organized service delivered by medical and nursing professionals, which provides for twenty four (24) hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds.

**21.220 GENDER-RESPONSIVE WOMEN'S TREATMENT IN SUBSTANCE USE DISORDER PROGRAMS [Eff. 11/1/13]**

In addition to Section 21.210, agencies licensed to provide Gender-Responsive Women's Treatment shall be in compliance with Subsections 21.220.1 through 21.220.4.

**21.220.1 GENERAL PROVISIONS [Eff. 11/1/13]**

- A. Treatment staff shall have documented training, supervision and experience in women-specific issues and services.
- B. Treatment for substance use disorders shall be provided to the family as a whole, unless clinically contraindicated. Clinical contraindications to this provision must be documented in the individual record.
- C. Agencies shall offer any pregnant woman admission to treatment within forty-eight (48) hours and shall demonstrate compliance with Section 21.220.4, D, Services to Pregnant Women.
- D. Agencies providing gender specific women's treatment shall include the following components:
  - 1. Emotional and physical safety of individuals take precedence over all other considerations in the delivery of services;
  - 2. Services designed to increase women's access to care, and engagement and retention of individuals (such as comprehensive case management, transportation, child care);
  - 3. Women-only therapeutic environments;
  - 4. Women-specific service needs and topic areas;

5. Program services shall directly address trauma issues currently manifesting in the individual's life either through direct service provision or by referral; and,
  6. Multiple modalities that meet the specific needs of women (group and individual therapy, case management and opportunities for women to be in treatment with their children where possible).
- E. Agency policy and procedures shall include the mandatory reporting of suspected child abuse, neglect and/or child safety issues, which shall include definitions of abuse and neglect under the Colorado Children's Code (Section 19-1-103, C.R.S.), and which are consistent with the reporting of child abuse allowed under federal law.
- F. Agency policy and procedures shall include the criteria for interventions offered and expected outcomes of services delivered.

**21.220.2 SCREENING [Eff. 11/1/13]**

In addition to the Section 21.190.3, screening shall include all of the following unless clinically contraindicated:

- A. Screening and documentation of individual's need for prenatal care (where applicable), primary medical care and family planning services;
- B. Screening for child safety issues utilizing an evidence-based or best practices approved instrument.

**21.220.3 TREATMENT [Eff. 11/1/13]**

- A. Service plans shall be established in accordance with Section 21.190.4 of these rules, and shall address each of the need areas identified in Section 21.220.3.
- B. When not clinically contraindicated the following topic areas shall be addressed in treatment or by referral when applicable:
  1. Reductions or elimination of substance use;
  2. Individual safety issues
  3. Child safety issues;
  4. Trauma issues;
  5. Parenting issues;
  6. Ways in which substance use disorders impact and are impacted by family and relationships;
  7. Medical and primary health issues;
  8. Mental health issues;
  9. Nutrition.

**21.220.4 SERVICES TO PREGNANT WOMEN [Eff. 11/1/13]**

- A. Pregnant women shall be given priority admission to treatment for substance use disorders.
- B. Programs shall develop policies and procedures for service delivery to pregnant women, which shall include circumstances under which pregnant women may be discharged from treatment.
  - 1. Pregnant women may not be discharged from treatment solely for failure to maintain abstinence from substance use.
  - 2. Every effort shall be made to retain pregnant women in treatment for the duration of their pregnancies in order to maintain an optimal period of abstinence from substance use.
- C. Every attempt shall be made to admit pregnant women to treatment within forty-eight (48) hours of first contact between the woman and the admitting program.
- D. If a pregnant woman is not admitted to treatment within forty-eight (48) hours of first contact, the denial shall be clearly documented, the women's treatment coordinator for OBH shall be informed, and interim services shall be provided consisting of the following at minimum:
  - 1. Referral for pre-natal care;
  - 2. Information on the effects of alcohol and drug use on the fetus;
  - 3. Daily phone contact with the individual; and,
  - 4. Education regarding the transmission and prevention of communicable diseases such as HIV, hepatitis.
- E. Pregnant women shall be linked to prenatal care immediately and barriers to accessing prenatal care shall be addressed, including transportation to prenatal care.
- F. When a woman refuses to seek prenatal care or fails attempts to link her to care, this shall be documented in her record, and there shall be continuing efforts to link her to prenatal care until this is accomplished.

**21.230 SUBSTANCE USE DISORDER EDUCATION AND TREATMENT FOR PERSONS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM**

**21.230.1 GENERAL PROVISIONS [Eff. 5/1/16]**

- A. Education, treatment, and ancillary services shall be provided to individuals convicted of misdemeanors and felonies who are assessed as needing substance use disorder treatment, as provided by Title 16, Article 11.5, Part 1, and C.R.S. and in accordance with current standardized assessment and placement protocol.
- B. All agencies admitting out of state offenders must identify and notify the Interstate compact unit for Adult Offender Supervision per Section 17-27.1-101, C.R.S.
- C. Services shall be based on the results of current screening and assessments.

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- D. Agencies shall place individuals involved in the criminal justice system according to the Standardized Offender Assessment Revised (SOA-R) screening and placement criteria. No amendments or later editions are incorporated. A copy of the SOA-R screening tool is available for inspection during regular business hours at the Colorado Department of Human Services, Office of Behavioral Health, Director of Community Programs, 3824 W. Princeton Circle, Denver, Colorado 80236 or at the Colorado Department of Public Safety, Division of Criminal Justice, 700 Kipling Street, #1000, Denver, Colorado 80215.
- E. Education, treatment and ancillary services as indicated by assessment and included in the service plan shall be provided for by the agency or through referrals.
- F. Agencies shall have a written memorandum of understanding with ancillary providers to make available agreed upon services and require specific data and exchange of information related to the individualized services.
- G. Education and treatment shall be a minimum of nine (9) months or as required by the referring criminal justice agency.
- H. Frequency and intensity of education and treatment services shall be based on assessments and at minimum one two hour session per week.
- I. The following content/topics shall be presented during offender treatment:
1. Physiological and psychological effects of alcohol, marijuana and/or marijuana/THC infused products, stimulants, and other drugs;
  2. Signs and symptoms of substance use disorders;
  3. Stress management and substance use disorders;
  4. Anger management and substance use disorders;
  5. Behavioral triggers leading to substance use disorders;
  6. Drugs in the work place; and,
  7. Legal issues and substance use disorders.
- J. Agencies shall implement treatment curricula that are written in manual format and are evidence-based or best practices. All agency clinical staff working with the individuals involved in the criminal justice system population must be trained on and follow the specific curricula as written.
- K. Individuals will receive a complete copy of the participant materials/workbook associated with the approved curriculum. The agency may charge for the curriculum.
- L. Education and treatment sessions shall only consist of face-to-face (as defined in Section 21.240.1) contact and shall not include administrative procedures or breaks.
- M. Agency staff working directly with individuals shall have documented qualifications and training in forensic populations and criminal justice systems.
- N. Drug and alcohol toxicology collection must be observed by trained staff when requested by the referral source.

- O. Records shall contain monthly documentation of communication with the criminal justice referral source describing progress toward specific treatment goals. Agencies shall be responsible for monitoring and reporting to referring courts or their representatives the individual's progress with ancillary services.
- P. Agencies shall have written documentation in an individual's record that the individual has received services to assist in community reintegration, if applicable.

**21.230.2 ENHANCED OUTPATIENT EDUCATION AND TREATMENT SERVICES FOR PERSONS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM [Eff. 5/1/16]**

- A. An agency may provide enhanced outpatient services if it:
  - 1. Is licensed by the Department for education and treatment services for individuals involved in the criminal justice system;
  - 2. Is in compliance with Section 21.230.1; and,
  - 3. Provides a minimum of four (4) hours over two (2) group sessions of scheduled treatment per week.
- B. Frequency and intensity of treatment activities shall be based on current assessments and conducted in at least two (2) sessions per week.
- C. Changes in frequency and intensity of education and treatment activities shall be assessed.
- D. If, upon discharge from enhanced outpatient treatment, the minimum number of months required by the referring criminal justice agency have not been met, the agency shall transfer the individual to the appropriate level of care where remaining education and treatment requirements can be met.

**21.240 DUI/DWAI, BUI, AND FUI EDUCATION AND TREATMENT**

**21.240.1 DEFINITIONS [Eff. 5/1/16]**

“ADDS” is the Alcohol and Drug Driving Safety program, established under Section 42-4-1301.3, C.R.S. The Judicial Department administers an Alcohol and Drug Driving Safety program in each judicial district that provides pre-sentence and post-sentence alcohol and drug evaluations on all persons convicted of Driving, Flying, and Boating Under the Influence (DUI, FUI, BUI) and Driving With Ability Impaired (DWAI).

“Alcohol and Drug Evaluation Specialists” (ADES) are persons within the criminal justice system, qualified to conduct pre- and post-sentence evaluations on, and provide supervision for, persons convicted of Driving, Flying, and Boating Under the Influence (DUI, FUI, BUI) and Driving With Ability Impaired (DWAI).

“BUI” means Boating Under the Influence.

“DUI” means Driving Under the Influence.

“DWAI” means Driving With Ability Impaired.

“Face-to-Face”, for purposes of this section 21.240, means that the individual is physically in the same room as a professional person at an office of behavioral health licensed or approved site.

“FUI” means Flying Under the Influence.

“Persistent Drunk Driver” defined in Section 42-1-102(68.5), C.R.S.

**21.240.2 GENERAL PROVISIONS [Eff. 5/1/16]**

- A. Agencies providing DUI/DWAI services shall develop and implement policies, procedures, and individualized service planning demonstrating recognition of issues and treatment needs unique to this individual population.
- B. Alcohol and Drug Driving Safety (ADDS) education and treatment services shall be restricted to those arrested, convicted of or receiving deferred prosecutions, sentences, or judgments for alcohol/other drug offenses related to driving (Title 42, Article 4, Part 13, C.R.S. and Title 42, Article 2, Part 1, C.R.S.), boating (Title 33, Article 13, Part 1, C.R.S.), or flying (Title 41, Article 2, Part 1, C.R.S.).
- C. Individuals who are admitted, educated, or treated for Driving Under the Influence (DUI), Driving While Ability Impaired (DWAI), Boating Under the Influence (BUI), or Flying Under the Influence (FUI) shall be screened, referred and placed in accordance with current ADDS program screening, referral, and placement procedures.
  - 1. If an agency does not have a copy of the ADDS referral paperwork, the agency shall conduct a screening of the individual using an evidence-based screening or promising practice process and instrument.
  - 2. If an appropriate level of service has not been determined by the ADDS program screening, the agency shall follow guidelines established by the Colorado Department OF Human Services, Office of Behavioral Health, to determine the most appropriate level of service.
- D. Agencies that do not provide services as identified through the screening or in the individual's court order shall:
  - 1. Refer the individual back to the Alcohol and Drug Evaluation Specialist with documentation of which service(s) will not be provided on site and identified referrals and suggestions for alternative services;
  - 2. Have a written memorandum of understanding or contract with the ancillary provider to make available agreed upon services and require specific data and exchange of information related to the individualized services; and,
  - 3. Be responsible for monitoring and reporting to referring courts or their representatives the individual's progress with ancillary services.
- E. Individuals with DUI/DWAI shall not be treated in groups with individuals with other offenses unless they need these groups as determined by the assessment and supported by the service plan.
- F. Agencies providing Level I Education, Level II Therapeutic Education, and Level II Therapy shall submit information using reporting formats and data systems approved by the Department when appropriate to:
  - 1. Sentencing courts;
  - 2. The Department;

3. Probation departments;
  4. Alcohol and Drug Evaluation Specialist;
  5. Department of Revenue Hearing Section; and,
  6. Motor Vehicle Division.
- G. Information released shall be in accordance with federal and state confidentiality regulations and shall include:
1. Enrollment;
  2. Cooperation;
  3. Attendance, hours and weeks completed;
  4. Treatment status and progress;
  5. Education/treatment levels;
  6. Fee payment;
  7. Compliance with ancillary services; and,
  8. Discharge status.
- H. Agencies shall establish written policies and procedures to ensure that individual data is accurate and submitted within seven (7) business days of service or change in status.
- I. Level I education, Level II therapeutic education, and Level II therapy shall not be combined, nor shall hours completed for one count as hours completed in another.
- J. Individuals shall not be reported as finishing Level I education, Level II therapeutic education, or Level II therapy until all required content/topics have been completed over the minimum required hours and weeks.
- K. Agencies shall provide proof of individual enrollment and report individual status in Level II education and therapy, including discharge, to the Colorado Department of Revenue, Division of Motor Vehicles, within seven (7) business days using Department prescribed reporting formats, in accordance with Sections 42-2-132 and 42-2-144, C.R.S.
- L. Agencies shall provide accurate and timely submission of DUI/DWAI referral summaries (DRS) and other required data submitted through the Treatment Management System (TMS). Agency staff having access to the Treatment Management System shall do so in accordance with federal confidentiality laws.
- M. Discharge DUI/DWAI Referral Summary
- Agencies shall provide a copy of the discharge DUI/DWAI referral summary, validated with an agency authorized signature, to individuals and referral sources within ten (10) business days following discharge from education and/or treatment.
1. A copy of the discharge referral summary shall be provided to individuals at no charge;

2. The discharge referral summary shall not be withheld for any reason including, but not limited to, collection of outstanding balances; and,
3. Each discharge referral summary must reflect all DUI/DWAI services the individual received in a given treatment episode.

**N. Ignition Interlock**

1. Agencies shall screen all individuals with DUI/DWAI's for ignition interlock usage and requirements in accordance with the Department's interlock rules;
2. Agencies shall offer interlock counseling to those individuals who have installed, or plan to install, an ignition interlock device in accordance with Department rules; and,
3. Interlock counseling shall be offered on site or by referral to another Department licensed agency.

**21.240.3 PROVISION OF SERVICES [Eff. 5/1/16]**

- A. Agencies shall use and adhere to a curriculum written in a manual form that is evidence-based or a best practice specific to DUI/DWAI, and contains content and topic areas as determined by the Department.
- B. Agencies shall provide individuals with a complete copy of the participant materials and workbook associated with the approved curriculum being used. The agency may charge individuals for the curriculum materials.
- C. Agencies shall assign individuals to a specific class, group or individual session throughout the treatment episode. Individuals attending DUI/DWAI education may make up sessions missed by attending other education sessions that cover the missed content. Make-up groups for DUI/DWAI therapy are not allowed.
- D. Staff conducting DUI/DWAI, BUI and FUI education and therapy shall:
  1. Receive training in the curriculum;
  2. Meet the minimum staff qualifications per Sections 21.160 and 21.210.1, including credentialing and competency in group processes; and,
  3. Possess a CAC II, CAC III or LAC.
- E. Hours of attendance shall only be granted for face-to-face contacts and shall not include administrative procedures or breaks.
- F. Drug and alcohol toxicology collection must be observed by trained staff when requested by the referral source.

**21.240.4 YOUTH DUI, DWAI, BUI and FUI EDUCATION AND TREATMENT [Eff. 5/1/16]**

Licensed youth DUI/DWAI agencies shall comply with Section 21.200 Behavioral Health Services for Children and Adolescents, the adult DUI, DWAI, BUI, FUI rules (21.240) as well as the following:

- A. Youth under twenty-one (21) years of age that receive a DUI/DWAI are held to the same adult requirements under Alcohol and Drug Driving Safety (ADDS) education and treatment services as identified in (Title 42, Article 4, Part 13 and Title 42, Article 2, Part 1, C.R.S) boating (Title 33, Article 13, Part 1, C.R.S.), or flying (Title 41, Article 2, Part 1, C.R.S.) and includes Section [42-4-1301.3(3)(c)(IV)] , C.R.S.
- B. Agencies licensed to provide Youth DUI, DWAI, BUI, and FUI education and treatment shall also be licensed to provide DUI/DWAI education and treatment.
- C. Whenever possible providers shall hold a separate group for youth.
  - 1. Providers shall use clinical judgement when determining age appropriate placement of youth under twenty-one (21) years of age in an adult group.
  - 2. When youth are placed in an adult group, individual sessions shall be offered to meet the developmental needs of the youth, when applicable.
- D. Youth under twenty-one (21) years of age shall receive a complete copy, age appropriate materials/workbook, associated with the approved curriculum. The agency may charge for the curriculum.
- E. Parents, other supportive adults, or significant others, shall participate throughout the length of treatment, unless contraindicated.

**21.240.5 CONTENT OF RECORDS [Eff. 5/1/16]**

Individual records shall be maintained for all levels of education and therapy and follow Section 21.170 (Records Care and Retention, General Provisions) and include:

- A. Court documents regarding referral and classification and placement;
- B. Attendance, individualized progress notes, and course completion data;
- C. Descriptions of content and topics covered during each session;
- D. Relevant reports and records of communication;
- E. Copies of Discharge DUI/DWAI Referral Summary;
- F. Copies of education pre and post tests.

**21.240.6 Level I EDUCATION [Eff. 11/1/13]**

- A. Level I education shall be twelve (12) hours of face-to-face instruction; hours may include intake and pre/post-tests.
- B. No more than four (4) hours shall be conducted in one (1) calendar day.
- C. Level I education shall be conducted in outpatient settings.

**21.240.7 Level II THERAPEUTIC EDUCATION [Eff. 5/1/16]**

- A. Agencies applying for approval to conduct Level II therapeutic education must also apply for approval to conduct Level II therapy and meet the requirements of both.
- B. Provision of Services for Level II therapeutic education shall:
  - 1. Be conducted in outpatient settings;
  - 2. Consist of twelve (12) attended weeks and a total of twenty-four (24) face-to-face contact hours; and,
  - 3. Not be conducted concurrently with Level II therapy unless clinical rationale is documented. The combined time in Level II therapeutic education and Level II therapy shall not be less than the minimum number of weeks required for Level II therapy.
- C. Individuals shall not attend more than one (1) session of Level II education per week.

**21.240.8 LEVEL II DUI/DWAI THERAPY**

**21.240.81 LEVEL II Outpatient [Eff. 5/1/16]**

- A. Programs applying for approval to conduct Level II therapy must also apply for approval to conduct Level II therapeutic education and meet the requirements for both.
- B. Individuals in Level II therapy shall be assigned treatment tracks in accordance with the ADDS program placement criteria or Department placement guidelines in the absence of the ADDS placement criteria. If a track has not been assigned by the ADDS program, the agency shall assign a track based on the Department's track guidelines. The Department track guidelines are as follows:
  - 1. TRACK A. Individuals whose blood alcohol content was below the statutorily defined persistent drunk driving (PDD) level per Section 42- 1-102(68.5), C.R.S., and who have one offense for DUI/DWAI, BUI, or FUI. Track A is a minimum forty-two (42) face-to-face hours of group and/or individual Level II therapy conducted over twenty-one (21) or more weeks.
  - 2. TRACK B. Individuals whose blood alcohol content was at or above the statutorily defined PDD level per Section 42-1-102(68.5), C.R.S., and who have one offense for DUI/DWAI, BUI, or FUI. Track B is a minimum of fifty-two (52) face-to-face hours of group and/or individual Level II therapy conducted over twenty-six (26) or more weeks.
  - 3. TRACK C. Individuals whose blood alcohol content was below the statutorily defined PDD level per Section 42-1-102(68.5), C.R.S., and who have two or more offenses for DUI/DWAI, BUI, or FUI. Track C is a minimum of sixty-eight (68) face-to-face hours of group and/ individual Level II therapy conducted over thirty-four (34) or more weeks.
  - 4. TRACK D. Individuals whose blood alcohol content was at or above the statutorily defined PDD level per Section 42-1- 102 (68.5), C.R.S., and who have two or more offenses for DUI/DWAI, BUI, or FUI. Track D is a minimum of eighty-six (86) face-to-face hours of group and/or individual Level II therapy conducted over forty-three (43) or more weeks.
- C. Level II therapy shall be conducted only after Level II therapeutic education has been completed unless there is documented assessment and clinical rationale.

- D. Level II therapy group sessions (excluding enhanced or intensive outpatient) shall not be less than two (2) hours of therapeutic contact, and shall not include administrative procedures and breaks.
- E. Individuals are expected to attend group one (1) time per week. Clinical rationale for any changes in frequency of group attendance (fewer or more) shall be documented, and must reflect at least one (1) session per month. Therapy hours attended shall be conducted over the minimum number of weeks associated with the therapy track assigned.
- F. The assessment shall be updated at the onset of Level II therapy.
- G. Using the initial service plan as a basis, a revised service plan and subsequent reviews shall be developed for individuals in Level II therapy in accordance with Section 21.190.4.

**21.240.82 DUI/DWAI Enhanced Outpatient THERAPY [Eff. 5/1/16]**

- A. An agency licensed to provide DUI/DWAI services may qualify to provide enhanced outpatient therapy if it:
  - 1. Is approved by the Department for Level II therapy;
  - 2. Meets all the requirements in Sections 21.110 through 21.190, Sections 21.240.2, 21.240.3, and 21.240.5 and Section 21.240.81; and,
  - 3. Demonstrates ability to provide eight (8) hours of scheduled treatment activities per week.
- B. Level II DUI/DWAI enhanced outpatient therapy shall:
  - 1. Be based on assessments;
  - 2. Include a minimum of three (3) to maximum eight (8) hours of treatment activities;
  - 3. Be conducted over a minimum of two (2) calendar days per week; and,
  - 4. Not include Level II education.
  - 5. Shall include no more than two (2) hours of level ii therapy.
- C. DUI/DWAI enhanced outpatient services shall be in addition to any DUI/DWAI level or track requirements.
- D. Treatment activities shall be conducted for a minimum of ninety (90) calendar days.
- E. Changes in frequency and intensity of Level II enhanced outpatient treatment shall be driven and based on treatment service plan reviews.

**21.240.83 DUI/DWAI Intensive Outpatient THERAPY [Eff. 5/1/16]**

- A. An agency licensed to provide DUI/DWAI services may qualify to provide DUI/DWAI intensive outpatient therapy if it:
  - 1. Is approved by the Department for Level II therapy;

2. MeetS all the requirements in Sections 21.110 through 21.190, Sections 21.240.2, 21.240.3, and 21.240.5, and Section 21.240.81; and,
  3. Demonstrates ability to provide at least nine (9) hours of scheduled treatment activities per week.
- B. DUI/DWAI intensive outpatient treatment therapy shall:
1. Be based on assessments;
  2. Include a minimum of nine (9) hours of treatment activities;
  3. Be conducted over a minimum of three (3) calendar days per week;
  4. Not include Level II education; and,
  5. Shall include no more than two (2) hours of level ii therapy.
- C. DUI/DUI intensive outpatient services shall be in addition to any DUI/DWAI level or track requirement.
- D. The length of stay in level ii intensive outpatient shall be four (4) to six (6) weeks.
- E. Any changes in frequency and intensity of Level II intensive outpatient treatment shall be based on assessments and service plan reviews.

**21.240.84 Partial Hospitalization, Clinically Managed Low Intensity Residential Services, Clinically Managed High Intensity Residential Services, and Medically Monitored Intensive Residential Treatment [Eff. 5/1/16]**

- A. Partial Hospitalization, Clinically Managed Low Intensity Residential Services, Clinically Managed High Intensity Residential Services, and Medically Monitored Intensive Residential Treatment may qualify to provide DUI/DWAI therapy if they:
1. Meet all requirements under specific level of care in Section 21.210.5;
  2. Meet all requirements in Sections 21.240.2 and 21.240.3; and,
  3. Are affiliated with the Department licensed outpatient DUI/DWAI programs.
- B. In order for individuals to receive DUI/DWAI therapy credit for participation in Partial Hospitalization, Clinically Managed Low Intensity Residential Services, Clinically Managed High Intensity Residential Services, and Medically Monitored Intensive Residential Treatment, the assessed and identified DUI/DWAI treatment areas must be included in the individualized service plan.

**21.240.9 DUI/DWAI BEHAVIORAL HEALTH SERVICES [Eff. 5/1/16]**

Some behavioral health service contact hours and weeks may be included and reported as hours of Level II therapy. Credit for DUI/DWAI therapy hours may be given if the DUI/DWAI agency conducts a current comprehensive assessment and:

- A. The assessment and service plan support the need for behavioral health services.

- B. Supporting documentation that corresponds to requested hours and weeks of behavioral health services from the ancillary provider is requested and documented in the record.
- C. A discharge DUI/DWAI referral summary is completed for the hours and weeks granted.

**21.250 NON-HOSPITAL RESIDENTIAL WITHDRAWAL MANAGEMENT**

**21.250.1 GENERAL PROVISIONS [Eff. 5/1/16]**

- A. Non-hospital withdrawal management services shall provide twenty-four (24) hour supervised withdrawal from alcohol and/or other drugs in a residential setting.
- B. Withdrawal management policies and procedures shall be developed and implemented in accordance with federal and state regulations, Department rules, and in consultation with medical professionals qualified in substance use disorders.
- C. Programs shall provide collaboration and coordination with emergency mental health services as needed.
- D. Individual to staff ratios shall not exceed ten to one (10:1); and,
  - 1. Procedures for responding to periods of high client-traffic and/or emergency situations shall be conspicuously posted.
  - 2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more consumers are present.
- E. Policies and procedures shall be developed and implemented for handling individuals who are assessed as being a current threat to themselves or others and shall include appropriate uses of law enforcement and monitor any use of individual restraint and/or seclusion.

**21.250.2 ADMISSION AND MONITORING [Eff. 5/1/16]**

- A. Individuals admitted to withdrawal management services shall be intoxicated, under the influence, or in any stage of withdrawal from alcohol and/or other drugs.
- B. Withdrawal management admission procedures shall include at a minimum:
  - 1. Degree of alcohol and other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices;
  - 2. Initial vital signs;
  - 3. Need for emergency medical and/or psychiatric services;
  - 4. Inventorying and securing personal belongings;
  - 5. Substance use disorder history and the degree to which the use of substance affects personal and social functioning, as soon as clinically feasible following admission;
  - 6. Pregnancy screening;
  - 7. Administration of a validated clinical withdrawal assessment tool.

- C. Withdrawal management monitoring of individuals shall include:
1. Routine monitoring of physical and mental status including observation of individual;
  2. Vital signs taken at least every two (2) hours until they remain at the person's baseline for at least four (4) hours, and then taken every eight (8) hours thereafter until discharge.
  3. Documentation per shift to include all individual monitoring activities.

**21.250.3 SERVICE PLANNING [Eff. 5/1/16]**

- A. Withdrawal management agencies shall develop and implement service plans in accordance with Section 21.190.4 and address safe withdrawal, motivational counseling, and referral for treatment.
- B. Additional service planning shall be required for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions, which place individuals at additional risk during withdrawal management.
- C. Assessments of individual readiness for treatment and interventions based on the service plan shall be documented in the record.

**21.250.4 DISCHARGE [Eff. 5/1/16]**

- A. Discharge information provided to individuals and documented in records shall include Section 21.190.6 and:
1. Effects of alcohol and other drugs;
  2. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), tuberculosis, and other infectious diseases, and for pregnancy.
  3. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis C and other infectious diseases, and pregnancy;
  4. Availability of alcohol and other drug abuse treatment services.
- B. Discharge policies and procedures shall be developed and implemented including:
1. Assurance that blood alcohol levels no greater than 0.00 prior to discharge and vital signs within normal range;
  2. Communication with intoxicated individuals leaving treatment against staff recommendations, including the use of emergency commitments.
  3. Circumstances under which individuals shall be discharged, other than completing withdrawal management or leaving against staff recommendations.

**21.250.5 STAFF REQUIREMENTS [Eff. 5/1/16]**

- A. At least fifty percent (50%) of withdrawal management staff including on-call staff shall consist of certified addiction counselors or staff in the process of obtaining certification. Plans for certification shall be available for review. Full-time staff shall obtain at least a CAC I within eighteen (18) months of employment.

- B. Uncertified staff or staff without a plan for certification shall not comprise more than fifty percent (50%) of total withdrawal management staff.
- C. The staff person overseeing day-to-day operations shall be certified as a CAC III.
- D. There shall be documentation that all staff within ninety (90) consecutive calendar days of employment shall have training in, and/or be evaluated as having knowledge of, the following:
  - 1. Infectious diseases (AIDS HIV, Hepatitis C, TB), including universal precautions against becoming infected;
  - 2. Administering cardiopulmonary resuscitation (CPR) and First Aid;
  - 3. Monitoring vital signs;
  - 4. Conducting assessment and triage, including identifying suicidal ideation;
  - 5. Emergency procedures and their implementation;
  - 6. Collecting urine, and breath samples;
  - 7. Cultural factors that impact withdrawal management;
  - 8. Ethics and confidentiality;
  - 9. Individual records systems;
  - 10. De-escalating potentially dangerous situations;
  - 11. Basic counseling and motivational interviewing skills.

**21.260 ALCOHOL AND DRUG EMERGENCY COMMITMENTS [Eff. 5/1/16]**

- A. Emergency commitment policies and procedures, based on and in compliance with Sections 27-81-111 and 27-82-107, C.R.S., and these rules, shall be developed and implemented by the licensed withdrawal management programs to:
  - 1. Ascertain if grounds for commitment exist;
  - 2. Assure that individuals and their legal representatives receive copies of the application for emergency commitment forms and be advised verbally and in writing of the right to challenge commitment through the courts;
  - 3. Determine when grounds for emergency commitment no longer exist.
- B. The treatment facility administrator shall designate, in writing, qualified staff to assume responsibility for accepting, evaluating, informing, and providing treatment to individuals on emergency commitment.
- C. Applications for emergency commitments shall be prepared on Department designated forms.
- D. Daily evaluations for emergency commitment continuance shall be documented.

- E. If individuals on an emergency commitment require treatment in other licensed withdrawal management programs, transfers may be managed by the programs that initially authorized the commitments.
- F. When transferring individuals, withdrawal management programs shall use Department designated transfer forms. Completed copies shall be given to:
  - 1. Individuals or their legal representatives;
  - 2. The withdrawal management programs to which individuals are being transferred.
- G. When minors are transferred, parents or legal guardians who have given permission for treatment shall receive copies of transfer forms.
- H. When it is determined grounds for emergency commitment no longer exist, the individual shall be transferred to voluntary status and the emergency commitment discontinued and documented. A copy of the form shall be given to the individual and made part of the treatment record.

**21.270 ALCOHOL AND DRUG INVOLUNTARY COMMITMENTS [Eff. 5/1/16]**

- A. All agencies funded by the Department or by a designated Managed Service Organization shall be licensed to treat individuals on involuntary commitment in accordance with this section.
- B. Involuntary commitment policies and procedures shall be developed and implemented based on and in compliance with Sections 27-81-112 and 27-82-108, C.R.S.
- C. The Department shall be the legal custodian of individuals involuntarily committed to treatment.
- D. Passes shall be issued to individuals on involuntarily commitments in residential settings only if they are directly related to treatment. Passes shall not be issued during the initial thirty (30) days of treatment except in emergencies and with Department approval.
- E. The following information shall be reported to the Department:
  - 1. Non-compliance with program requirements and/or court orders;
  - 2. Failure to appear for admission to treatment;
  - 3. Leaving treatment in violation of court orders;
  - 4. Failure to return from passes;
  - 5. Treatment status every thirty (30) days.
- F. Discharge summaries, as outlined in Section 21.190.6 shall be submitted to the Department, the referring source, and to the referral treatment or aftercare agency.
- G. Requests for early discharge and/or transfer to other treatment programs shall be submitted to the Department for approval.

**21.270.1 STAFF REQUIREMENTS [Eff. 11/1/13]**

- A. Primary counselors for individuals on involuntary commitment shall:
  - 1. Be Colorado certified addiction counselors level II or III; or,

2. Be Colorado licensed addiction counselors; or,
  3. Possess a clinical master's degree; and,
  4. Complete fourteen (14) hours of training in interviewing techniques related to engaging individuals in treatment.
- B. Copies of course certificates and other relevant documentation shall be retained in counselor personnel files.

**21.280 CARE AND TREATMENT OF PERSONS WITH A MENTAL HEALTH DISORDER IN A DESIGNATED FACILITY**

**21.280.1 DEFINITIONS [Eff. 5/1/16]**

“Facility” for the purposes of this section means any facility designated by the Department pursuant to Title 27, Article 65, C.R.S.

“Involuntary Medication” means psychiatric medication administered without an individual's consent.

“Licensed Independent Practitioner” for the purposes of this section means a practitioner permitted by law and by the agency to provide care, treatment, or services, without direction or supervision, within the scope of the practitioner license and consistent with assigned clinical responsibilities.

“Placement facility” means a public or private facility that has a written agreement with a designated facility to provide care and treatment to any individual undergoing mental health evaluation or treatment by a designated facility. A placement facility may be a general hospital, nursing care facility, or licensed residential child care facility.

“Professional person” means a person licensed to practice medicine in Colorado, a psychologist certified to practice in Colorado, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in Colorado that is operated by the armed forces of the United States, the United States Public Health Service, or the United States Department of Veterans Affairs.

“Psychiatric medication” is a medication being used to treat psychiatric illness for the patient including, but not limited to, anti-psychotics, antidepressants, and other medications that may have other medical uses but are accepted within the medical profession for psychiatric use as well.

“Secure Treatment Facility” for the purposes of these rules, means the Robert L. Hawkins High Security Forensic Institute at the Colorado Mental Health Institute at Pueblo.

“Therapy or treatments using special procedures” means a therapy that requires an additional, specific consent, including electro-therapy treatment (electro-convulsive therapy), and behavior modifications using physically painful, aversive, or noxious stimuli.

**21.280.2 ORGANIZATIONAL PROVISIONS**

**21.280.21 Employment of Persons Receiving Services in Designated Facilities [Eff. 11/1/13]**

- A. All labor, employment or jobs involving facility operation and maintenance which are of an economic benefit to the facility, shall be treated as work and shall be compensated according to applicable minimum wage or certified wage rates.

- B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping, such as making one's bed or cleaning one's area, shall not be treated as work and shall not be compensated.
- C. Individuals shall not be forced in any way to perform work.
- D. Privileges or release from a designated facility shall not be conditioned upon the performance of work.
- E. Vocational programs and training programs must comply with all applicable federal and state laws.
- F. Vocational programs are not subject to the provisions in Section 21.280.21, A, unless the program is of economic benefit to the facility.
- G. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the individual's record.

**21.280.22 Environment and Safety [Eff. 11/1/13]**

- A. All individuals being treated under these regulations shall receive such treatment in a clean and safe environment with opportunities for privacy.
- B. A facility shall only place an individual in a bedroom with video monitoring due to good cause and safety or security reasons. Individuals shall be notified when placed in bedrooms with video monitoring capabilities.
- C. Each facility shall maintain reasonable security capabilities to guard against the risk of unauthorized departures. The least restrictive method to prevent an unauthorized departure shall be used.
- D. An unlocked facility may place an individual in seclusion to prevent an unauthorized departure when such departure carries an imminent risk of danger for the individual or for others. Under those circumstances, the seclusion procedures in Section 21.280.42, Use of Seclusion, shall be followed.
- E. Seclusion rooms must be a minimum of 100 square feet.

**21.280.23 Facility Designated Pursuant to Title 27, Article 65, C.R.S., Care and Treatment of Persons with Mental Illness Data Requirements [Eff. 5/1/16]**

- A. Each facility designated by the Department, pursuant to Title 27, Article 65 C.R.S, shall file an annual report with the Department. The report shall be submitted in the format and timeframe required by the Department. This data shall include individuals being treated in placement agencies under the auspices of the designated facility.
- B. The data report requirements shall include the following types of information as listed in 1 through 4:
  - 1. Seventy-Two (72) Hour Treatment and Evaluation (Mental Health Holds)

The facility is required to maintain a data set including the following for each period of July 1 through June 30:

- a. Number of individuals on seventy-two hour holds, their gender and ethnicity.

- b. Who initiated the hold, i.e., police, court, facility-based personnel and number of each type.
- c. Reason for hold, i.e., dangerous to self, dangerous to others, gravely disabled, and number of each type.
- d. Outcome of the hold, i.e., dropped, voluntary, certified, transferred and number of each type.
- e. Counties in which the holds were initiated and numbers per county.
- f. Number of holds per individuals eighteen (18) years of age and over.
- g. Number of holds per individuals seventeen (17) years of age and younger.

2. Short and Long-Term Certifications

The facility is required to maintain a data set including the following for each period of July 1 through June 30:

- a. Number of individuals on certifications, including gender and ethnicity of the individual.
- b. Type of certification, i.e., short-term, extended short-term, long-term, extended long-term and number of each type.
- c. Reason for certification, i.e., dangerous to self, dangerous to others, gravely disabled, and number of each type.
- d. Outcome of the certification, i.e., dropped, voluntary, continued, transferred, court ordered dropped and number of each type.
- e. Counties in which certifications are or were held and number of each type.
- f. Number of certifications per individuals eighteen (18) years of age and over.
- g. Number of certifications per individuals seventeen (17) years of age and younger.

3. Voluntary Individuals

The facility is required to maintain a data set of the number of individuals who are receiving mental health treatment voluntarily by age groups as listed above.

4. Every designated facility shall maintain the following data sets to be available for review and/or reporting to the Department. These data shall be incorporated into the quality improvement processes and systems of the facility.

- a. Involuntary Medications
  - 1) Numbers of individuals receiving involuntary (court-ordered or emergency) psychiatric medications.
  - 2) Type of order (Emergency or Court-Ordered).

b. Involuntary Treatments

- 1) Numbers of individuals receiving restraint and/or seclusion.
- 2) Type of restraint.
- 3) Length of restraint episode per individual.
- 4) Length of seclusion episode per individual.
- 5) Number of individuals receiving electroconvulsive therapies.

c. Imposition of Legal Disability or Deprivation of a Right

Numbers of individuals treated who are under a court order for imposition of legal disability or the deprivation of a right.

**21.280.24 Staff Training Requirements [Eff. 11/1/13]**

In addition to Section 21.160, facilities designated under these rules shall develop a training curriculum and schedule in order to meet the following requirements. Facilities may choose to use a certification of competency in lieu of training, and shall develop appropriate policies, procedures and testing to assure competency.

- A. All staff participating in the provision of the care and treatment for individuals with mental health disorders shall receive annual training or annual facility certification of competency on the provisions of these rules and the requirements of Section 27-65-101, et seq., C.R.S.
- B. All staff who administer involuntary medications shall receive annual training or annual facility certification of competency on Section 21.280 of these rules and the legal rationale underlying involuntary medication of individuals.
- C. All direct care staff shall receive annual training or annual facility certification of competency in the recognition and response to common side effects of psychiatric medications. These staff shall be trained to respond to emergency drug reactions in accordance with the facility's policies.
- D. All staff who administer restraint/seclusion techniques shall receive annual facility training or annual certification of competency on lower level behavioral interventions and Section 21.280.4 of these rules.
- E. All staff involved in the administration of the treatment program shall receive annual training or annual facility certification of competency on alternative or representative medical decision making, including, but not limited to advance directives, medical durable powers of attorney, and proxy decision making, and guardianships.
- F. Specific staff of placement facilities, as determined by the designated facility, shall receive annual facility training or annual certification of competency on the provisions of these rules and the requirements of Section 27-65-101, et seq., C.R.S.

**21.280.25 Placement Facilities [Eff. 5/1/16]**

- A. Facilities designated for seventy-two (72) hour evaluation and treatment, short-term, and long-term treatment may provide mental health services directly or through the use of placement facility contract. Whenever a placement facility is used there must be a written agreement with the designated facility. In either case, the designated facility is responsible for assuring an appropriate treatment setting for each individual and services provided in accordance with these rules. Whenever a placement facility is used, the designated facility shall be responsible for the care provided by the placement facility.
- B. All agreements between designated facilities and placement facilities and all supplemental agreements and amendments shall be submitted in writing to the Department no later than ten (10) business days after the effective date of the agreement or amendment.
- C. Only the following Colorado licensed facilities are eligible to be a placement facility:
  - 1. Nursing homes;
  - 2. Residential Child Care Facilities providing mental health services;
  - 3. Non-psychiatric hospitals providing in-patient medical services.
  - 4. Alternative Care Facilities.
- D. Emergency departments are not eligible to be, nor are considered placement facilities.
- E. Whenever a designated facility uses a placement facility, the agreement shall include:
  - 1. An annual training plan for placement facility staff that provides at a minimum training regarding mental health disorders, these rules, Title 27, Article 65, C.R.S., and appropriate, safe behavioral interventions. The implementation of the training plan shall be monitored by the designated facility;
  - 2. A requirement that supervision of direct care staff be provided by professional persons licensed in Colorado to practice medicine or a certified Colorado psychologist employed by or under contract with the designated facility, or designated professional person licensed in Colorado to practice medicine or a certified Colorado psychologist employed by the placement facility to be responsible for direct care supervision provided that the placement facility and the designated facility are operated by the same corporate entity;
  - 3. A requirement that assures the necessary availability and supervision of placement facility staff in order to carry out the contract; and,
  - 4. A requirement that the placement facility adheres to these rules through the placement facility agreement.
- F. Placement facilities agreements shall be executed and signed bi-annually when the designated facility submits its application for designation.
- G. A placement facility can be used by a designated facility, at its discretion under the provisions of these regulations, in order to provide care to any individual undergoing mental health evaluation or treatment. Designated facilities shall not place individuals in a placement facility unless all of the applicable provisions of these rules are met and placement in such facility is appropriate to the clinical needs of the individual. When a placement facility is required, the least restrictive facility possible and available must be used, consistent with the clinical needs of the individual.

H. A placement facility shall not provide services beyond the scope of its license.

**21.280.26 Individual Rights of Persons Receiving Evaluation Care or Treatment Pursuant to Title 27, Article 65, C.R.S. [Eff. 11/1/13]**

- A. Individuals shall be informed they have the same rights as any individual, except as limited by law. Among these are the rights to:
1. Receive services in the least restrictive setting, subject to available funding.
  2. Have an individualized service plan and the right to participate in the development and subsequent changes.
  3. Review the clinical record, as allowed by law.
  4. Designate a representative(s) verbally or in writing, to represent the individual's interests in matters related to grievances.
  5. Have access to a representative within the designated facility who provides assistance to file a grievance.
  6. Be informed by the designated facility that there will be no retaliation against an individual for exercising his or her rights.
- B. Facilities shall post individual rights in prominent places frequented by individuals receiving services.
- C. For Individuals receiving treatment in facilities designated pursuant to Title 27, Article 65, C.R.S.:
1. The facility shall furnish all individuals receiving evaluation, care or treatment under any provisions of Title 27, Article 65, C.R.S., with a written copy of the rights listed under Subsection 21.280.26, C, 2 (translated into a language that the individual understands) upon admission. If the individual is not able to read the rights, the individual shall be read the rights in a language that s/he understands. These rules shall be interpreted by the Department in accordance with a standard of reasonableness.
  2. The facility shall post the following list of rights (in appropriate languages) in prominent places frequented by individuals and their families receiving services:
    - a. To receive and send sealed correspondence. No incoming or outgoing correspondence shall be opened, delayed, held or censored by the personnel of the facility;
    - b. To have access to letter writing materials, including postage, and to have staff members of the facility assist him/her if unable to write, prepare and mail correspondence;
    - c. To have reasonable and frequent access to a telephone, both to make and receive calls in privacy;

- d. To have frequent and convenient opportunities to meet with visitors. The facility may not deny visits by the individual's attorney, religious representative or physician at any reasonable time. The facility will provide privacy to maintain confidentiality of communication between an individual and spouse or significant other, family member(s), staff member(s), attorney, physician, certified public accountant and religious representative, except that if disclosure is required by law, then such privacy may be terminated;
  - e. To wear his or her own clothing, keep and use his/her own individual possessions within reason and keep and be allowed to spend a reasonable sum of his/her own money;
  - f. To refuse to take psychiatric medications, unless the individual is an imminent danger to self or others or the court has ordered administration of such medications;
  - g. To not be fingerprinted unless required by law;
  - h. To refuse to be photographed except for facility identification and the administrative purposes of the facility. Photographs and/or video recordings shall be confidential and shall not be released by the facility except pursuant to court order. No other non-medical photographs and/or video recordings shall be taken or used without appropriate consent or authorization (Section 27-65-117(4), C.R.S.).
  - i. For individuals who are under certification for care and treatment, to receive twenty-four (24) hour notice before being transferred to another designated or placement facility unless an emergency exists, and the right to have the transferring facility notify someone chosen by the individual about the transfer;
  - j. To confidentiality of treatment records except as required by law;
  - k. To accept treatment voluntarily, unless reasonable grounds exist to believe the individual will not remain in treatment on this basis;
  - l. To receive medical and psychiatric care and treatment in the least restrictive treatment setting possible, suited to meet the individual's needs and subject to available resources;
  - m. To request to see his/her clinical record, to see the records at reasonable times, and if denied access, to be given the reason upon which the request was denied and have documentation of such placed in the individual record;
  - n. To retain and consult with an attorney at any reasonable time; and,
  - o. Every individual who is eighteen (18) years of age or older shall be given the opportunity to exercise his/her right to vote in primary and general elections. The staff of the designated or placement facility shall assist each individual in obtaining voter registration forms and applications for absentee or mail ballots, and in complying with any other prerequisite for voting.
- D. With every mental health hold (M-1) and petition to court for involuntary treatment resulting in a change of legal status, the facility shall advise an individual of his or her rights set forth in this Section 21.280.26, and there shall be evidence of such advisement in the individual's clinical record.

E. Individual Rights Restrictions in Facilities Designated Pursuant to 27-65

1. As set forth in Section 27-65-117, C.R.S., an individual's statutory rights, Section 21.280.26, C, 2, a-e may be limited or denied for good cause by the Colorado licensed physician or psychologist who is providing treatment, as follows:
  - a. Except as otherwise provided in Section 21.280.26, E, 2, each denial of an individual's right shall be made on a case by case basis and the reason for denying the right shall be documented in the individual record and shall be made available, upon request, to the individual or his/her attorney.
  - b. Except as otherwise provided in Section 21.280.26, E, 2, restrictions on rights in Section 21.280.26, C, 2, a-e, shall be evaluated for therapeutic necessity on an ongoing basis and the rationale for continuing the restriction shall be documented at least every seven (7) calendar days.

2. Secure Treatment Facilities

A Colorado licensed physician or psychologist treating persons in a secure treatment facility may limit or deny rights for good cause based upon the safety and security needs of the staff and other individuals in the facility. Safety and security policies applicable to the unit shall be incorporated into the individual's service plan. The following procedures shall be adhered to:

- a. The Department shall approve of safety and security policies for each facility unit that places any limit on the rights set forth in Section 21.280.26 as well as the policy and criteria for placement of an individual committed under Title 27, Article 65, C.R.S., in secure treatment facilities.
- b. The safety and security policies for each facility unit shall be posted in the unit. The secure facility staff shall provide a copy of the unit policy upon an individual's request.
- c. Any good cause restriction of rights based upon the safety and security policy of the facility unit shall be noted in the individual's record. The order for restriction shall be signed by the Colorado licensed physician or psychologist providing care and treatment, and shall be reviewed at least every thirty (30) days.
- d. No safety or security policy may limit an individual's ability to send or receive sealed correspondence. However, to prevent the introduction of contraband into the secure treatment facility, the policy may provide that the individual open the correspondence in the presence of unit staff.
- e. No safety or security policy may limit an individual's right to see his or her attorney, clergy, or physician at reasonable times. However, the safety and security policy may provide that advance notice be given to the secure treatment facility for such visits so that the secure facility can adequately staff for the private visit, and take any measures necessary to ensure the safety of the visit.

- f. For the purposes of this rule, placement of individuals in secure treatment facilities on units that are locked at night:
  - 1) Individuals transferred to a secure treatment facility from the Department of Corrections, who are serving a sentence in the Department of Corrections, may be placed on units in which the bedroom doors are locked during sleeping hours.
  - 2) All other individuals who are newly admitted to a secure treatment facility may be placed on units in which the bedroom doors are locked during sleeping hours, for a time period not to exceed sixty (60) calendar days. After sixty (60) calendar days, these individuals will not be placed on a unit with locked doors during sleeping hours unless an individualized assessment is made and the treatment team determines that the individual is imminently dangerous to him/herself or to others.
  - 3) Sleeping hours shall begin no earlier than 9:00 p.m., end no later than 8:00 a.m., and shall not exceed 8-1/2 hours.
  - 4) Individuals shall be provided an effective means of calling for assistance when in a locked room during sleeping hours. The secure treatment facility shall provide staff to promptly assist an individual with his or her individual needs including, but not limited to, staff assigned to a day hall where staff will be able to hear and respond to individuals who knock on their room doors. An intercom call system may also be used. Staff shall monitor each individual's well-being through visual observation checks every fifteen (15) minutes.

F. As set forth in Sections 27-65-104 and 27-65-127, C.R.S., an individual's rights may be limited or denied under court order by an imposition of legal disability or deprivation of a right.

G. Information pertaining to the denial of any right shall be made available, upon request, to the individual or his/her attorney.

### **21.280.3 MEDICAL AND MEDICATION TREATMENT PROVISIONS**

#### **21.280.31 Medical/Dental Care [Eff. 11/1/13]**

A. Seventy-Two (72) Hour Treatment and Evaluation Facilities

The facility shall ensure the availability of emergency medical care to meet the individual needs of each individual. The facility shall have and adhere to a written plan for providing emergency medical care to include at least:

- 1. A qualified licensed independent practitioner responsible for the completion of physical examinations within twenty-four (24) hours of admission.
- 2. The availability of a physician or access to an emergency medical facility on a twenty-four (24) hour, seven (7) days a week basis.
- 3. Emergency medical treatment, when indicated, shall be accessed immediately (within one hour) upon determination that an emergency exists.

4. Whenever indicated, an individual shall be referred to an appropriate specialist for either further assessment or treatment. The facility shall be responsible for securing an appropriate assessment to determine the need for further specialty consultation. This information shall be contained in the clinical record.

**B. Short-Term and Long-Term Treatment Facilities**

The facility shall ensure the availability of medical care and emergency dental care to meet the individual needs of each individual. The facility shall have and adhere to a written plan for providing medical and emergency dental care to include at least:

1. A qualified licensed independent practitioner responsible for the completion of physical examinations within twenty-four (24) hours of admission. Subsequent physical examinations shall be completed annually. This information shall be included in the clinical record.
2. The availability of a qualified licensed independent practitioner or emergency medical facility on a twenty-four (24) hour, seven (7) days a week basis.
3. Emergency medical treatment, when indicated, shall be accessed immediately (within one hour) upon determination that an emergency exists.
4. Whenever indicated, an individual shall be referred to an appropriate specialist for either further assessment or treatment. The facility shall be responsible for securing an appropriate assessment to determine the need for further specialty consultation. This information shall be contained in the clinical record.
5. Ongoing appraisals of the general health of each individual, including need for immunizations in accordance with applicable state and federal law and need for corrective and assistive devices such as glasses, hearing aids, prostheses, dentures, walkers, etc. This information shall be contained in the clinical record.

- C. The obligation to ensure the availability of emergency medical services shall not be construed as the obligation to pay for such services; however, the facility shall secure these services regardless of source of payment.

**21.280.32 Psychiatric Medications [Eff. 11/1/13]**

- A. In all instances where prescription psychiatric medications are to be ordered as a part of a mental health treatment program, the following information shall be provided to the individual and legal guardian(s). For children under the age of fifteen (15), the following information shall be provided to the child's parent(s) or legal guardian(s). When an individual has designated another to act concerning medication issues pursuant to a medical durable power of attorney, advanced directive, or proxy, the information shall be provided to that individual also.

1. The name(s) of the medication being prescribed.
2. The usual uses of the medication(s).
3. The reasons for ordering the medication(s) for this individual.
4. A description of the benefits expected.
5. The common side effects and common discomforts, if any.

6. The major risks, if any.
  7. The probable consequences of not taking the medication(s).
  8. Any significant harmful drug or alcohol interactions, or food interactions.
  9. Appropriate treatment alternatives, if any.
  10. That s/he may withdraw agreement to take the medication at any time.
- B. The facility shall have policies and procedures for documenting in the clinical record that the required information was given to the individual, custodian, or guardian and consent obtained before administration of medication(s).
- C. The provider with prescriptive authority or his/her designee shall offer to answer inquiries regarding the medication(s).
- D. No individual shall be threatened with or subjected to adverse consequences by facility staff solely because of a failure to accept psychiatric medication voluntarily.
- E. If an individual has established an advance directive concerning psychiatric medication and the advance directive is still in effect, the Colorado licensed physician or psychologist shall follow the directive unless contraindicated in a psychiatric emergency.
- F. Prescribing, Handling, Administration of Psychiatric Medication(s)

All psychiatric medication(s) shall be administered on the written order of a physician or other professional authorized by statute to order such medications. Verbal medication orders may be given according to facility policies.

1. The facility shall have written policies and procedures regarding Section A, above, and the following:
  - a. Documentation of the administration of medication, medication variances/errors, and adverse medication reactions related to medication administration;
  - b. Notification to a physician or other professional authorized by statute to order such medications in case of medication errors and/or medication reactions/events;
  - c. Discontinuance of medication;
  - d. Disposal of medications; and,
  - e. Acceptance of verbal, fax, or electronically transmitted medication orders.
2. The facility shall note in the individual clinical record all prescription medications administered to the individual by the facility including:
  - a. The name and dosage of medication;
  - b. The reason for ordering the medication;
  - c. The time, date and dosage when medication(s) is administered;

- d. The name and credentials of the individual who administered the medication;
- e. The name of the prescribing professional authorized by statute to order such medication; and,
- f. If the medication is administered as an emergency medication or a court-ordered medication.

**21.280.33 Involuntary Psychiatric Medications [Eff. 11/1/13]**

These rules do not apply to refusal of non-psychiatric medications or medical emergencies. If an individual refuses medications intended to treat general medical conditions and that refusal is likely to cause or precipitates a medical emergency, those professionals who are authorized to order and administer medications may take action in accordance with generally accepted medical practice in an emergency situation.

**21.280.34 Psychiatric Emergency Conditions [Eff. 11/1/13]**

- A. Individuals who are detained pursuant to Sections 27-65-105, 106, 107, 108 or 109, C.R.S., and refuse psychiatric medication may be administered psychiatric medication(s) ordered up to twenty-four (24) hours without consent under a psychiatric emergency condition.
- B. An emergency condition exists if:
  - 1. The individual is determined to be in imminent danger of harming herself/himself or others, as evidenced by symptoms which have in the past reliably predicted imminent dangerousness in that particular individual; or,
  - 2. By a recent overt act, including, but not limited to, a credible threat of bodily harm, an assault on another individual or self-destructive behavior.
- C. A reasonable attempt to obtain voluntary acceptance of psychiatric medication shall be made prior to the use of involuntary medication.

**21.280.35 Continuation of a Psychiatric Emergency [Eff. 11/1/13]**

- A. If the psychiatric emergency has abated because of the effect of psychiatric medications and the physician is of the opinion that psychiatric medication is necessary to keep the emergency in abeyance beyond seventy-two (72) hours, then within that seventy-two (72) hours the following steps shall be taken:
  - 1. The facility shall send a written request for a court hearing for an order to administer the medication involuntarily; and,
  - 2. A documented concurring consultation with another physician shall be obtained. The consultation shall include an examination of the individual and a review of the clinical record including an assessment as to whether the psychiatric emergency condition continues to exist.
  - 3. If a concurring consultation is not obtained within seventy-two (72) hours, then emergency psychiatric medication shall be discontinued until such concurring consultation is obtained and documented, except in cases where life threatening consequences could result from an abrupt medication discontinuation. Under these circumstances, the individual shall be safely taken off the medication according to standards of medical practice, with corresponding clinical documentation.

4. In no case shall an individual receive emergency psychiatric medication(s) involuntarily for a period exceeding ten (10) days without an order from a court of competent jurisdiction, including continuation orders from the court.
  5. The individual shall be notified of the right to contact his or her attorney and/or the court of competent jurisdiction at the time the written request for court-ordered medication is made. This notification shall be documented in the clinical record. If an individual chooses to exercise this right, the designated facility shall aid the individual if necessary, in accomplishing the foregoing.
- B. The specific facts outlining behaviors supporting the finding of the emergency condition shall be detailed in the clinical record. Every twenty-four (24) hours thereafter until such time a final court order is issued, the emergency is resolved, or the individual accepts psychiatric medications voluntarily, the facility shall document the behaviors that substantiated the need to continue the emergency medication, and the physician shall reorder the psychiatric medications.
- C. During the course of emergency medication administration, the individual shall be offered the medication on a voluntary basis each time the medication is given. If the individual voluntarily consents to take the medication(s), and the attending physician determines that the individual will likely continue to accept the medication on a voluntary basis and no longer requires involuntary medications, this shall be documented in the record and the involuntary medication procedures shall be terminated.
- D. If the individual again refuses to voluntarily accept medication(s) and his or her clinical condition returns to an emergency situation as defined in Section 21.280.34, the emergency psychiatric medication procedures may be re-instituted.

**21.280.36 Non-Emergency Involuntary Medications [Eff. 11/1/13]**

- A. In non-emergency situations in which an individual who is detained pursuant to Sections 27-65-106, 107, 108, or 109, C.R.S., would benefit from the administration of a psychiatric medication, but the individual does not consent, the facility shall petition the court to obtain permission to administer such medication. The following conditions must be documented in the petition:
1. The individual is incompetent to effectively participate in the treatment decision;
  2. Treatment by psychiatric medication is necessary to prevent a significant and likely long-term deterioration in the individual's mental condition or to prevent the likelihood of the individual causing serious harm to him/herself or others;
  3. A less intrusive appropriate treatment alternative is not available; and,
  4. The individual's need for treatment by psychiatric medication is sufficiently compelling to override any bona fide and legitimate interest of the individual in refusing treatment.
- B. The petition shall specify what class or name of psychiatric medication is being recommended as potentially beneficial to the individual.
- C. No psychiatric medications shall be administered without the individual's consent until a court order is received authorizing involuntary use, except under emergency conditions under Section 21.280.34.

**21.280.37 Involuntary Medication Data [Eff. 11/1/13]**

If the facility uses a medication administration record or another mechanism which meets the criteria listed in Section B, below, can correlate this information as required in Section C, below, and places the information in the clinical record, that mechanism may be used in lieu of a separate log.

- A. The designated facility must maintain a log of all cases where involuntary medications were administered.
- B. The record shall contain, at a minimum, the following:
  - 1. Individual's name and identifying number.
  - 2. Specified use of involuntary medication.
  - 3. Physician or other professional authorized by law ordering involuntary medication.
  - 4. Date/time each involuntary medication was administered.
  - 5. Date/time involuntary medication was discontinued.
  - 6. Reason for discontinuation of involuntary medication(s).
- C. The facility shall have the ability to determine, at a minimum, the aggregate number of individuals receiving emergency and involuntary psychiatric medications during a specified period of time, the start and stop dates for each individual's involuntary medication treatment, and shall incorporate the use of this data into the quality improvement program.

**21.280.4 SECLUSION, RESTRAINT, AND PHYSICAL MANAGEMENT FOR 27-65 DESIGNATED FACILITIES [Eff. 11/1/13]**

The following rules covering seclusion and restraint apply to all areas of the designated facility including emergency departments and to placement facilities. If a facility is authorized to use physical management, restraint or seclusion at the facility, the facility shall use physical management, restraint or seclusion only in accordance with the following rules unless the specific rules prohibit, limit or modify the requirements placed upon the facility.

- A. Individuals being detained under Sections 27-65-105 through 109, C.R.S., may be secluded or restrained over their objection under the conditions in Section 21.280.4; otherwise, there must be a signed informed consent for such an intervention as outlined in Section 21.280.5 of these rules.
- B. These rules do not supersede any requirements under Section 26-20-101, et seq., C.R.S.
- C. Staff shall ensure that no individual will harm or harass an individual who is secluded and/or restrained.
- D. These measures may only be used in accordance with a service plan developed in consultation with and based on a written order by a Colorado licensed physician or psychologist. The service plan, which shall document if less restrictive measures were unsuccessful, shall be evaluated by a Colorado licensed physician or psychologist every twenty four (24) hours.

**21.280.41 Definitions [Eff. 11/1/13]**

“Mechanical Restraint” means a physical device used to involuntarily restrict the movement of an individual or the movement or normal function of a portion of his or her body. Types of mechanical restraints include, but are not limited to: restraint sheets, camisoles, belts attached to cuffs, leather armlets, restraint chairs, and shackles.

“Physical Management” means the physical action of placing one’s hands on an individual. Physical management may be used to gain physical control in order to protect the person or others from harm after all attempts to verbally direct or de-escalate the person have failed. Physical management may be utilized when an emergency situation exists. The physical management continuum may include:

- A. Utilizing transitional measures.
- B. Placing one’s hands on a person to physically guide and/or physically control the person.
- C. Use of an approved restraint method to control or contain the person.
- D. Placing of a person into an approved prolonged restraint method.
- E. Physical management may be used to move or escort a person into seclusion. Seclusion, in itself, is not a form of physical management.

“Physical Restraint” means the use of bodily, physical force to involuntarily limit a person’s freedom of movement, except that “physical restraint” does not include the holding of a child by one adult for the purpose of calming or comforting the child.

“Seclusion” means the confinement of a person alone in a room from which egress is prevented. Seclusion does not include the placement of persons, who are assigned to an intake unit in a secure treatment facility, in locked rooms during sleeping hours pursuant to Section 21.280.26.E thru G.

**21.280.42 Use of Seclusion [Eff. 11/1/13]**

- A. Seclusion may be used only for the purpose of preventing imminent injury to self or others, or to eliminate prolonged and serious disruption of the treatment environment. Any time an individual is placed alone in a room and not allowed to leave, it shall be construed as seclusion.
- B. An unlocked designated facility may place an individual in seclusion to prevent an unauthorized departure when such departure carries an imminent risk of dangerousness for the individual or for others. Under those circumstances, the seclusion procedures in this section shall be followed.
- C. Any decision to seclude shall be based on a current clinical assessment, and may also be based on other reliable information including information that was used to support the decision to take the individual into custody for treatment and evaluation. The fact that an individual is being evaluated or treated under Sections 27-65-105 through 27-65-109, C.R.S., shall not be the sole justification for the use of seclusion.
- D. Seclusion shall be used only when other less restrictive methods have failed. Documentation of less restrictive methods and the outcome shall be contained in the clinical record.
- E. Seclusion rooms shall be lighted, clean, safe, and have a window for staff to observe.
- F. Seclusion shall only be ordered by a Colorado licensed physician or psychologist.

- G. Seclusion shall not be used for punishment, for the convenience of staff, or as a substitute for a program of care and treatment.

**21.280.43 Use of Restraint [Eff. 11/1/13]**

Restraint may be used in emergency circumstances, wherein the individual presents a serious, probable imminent threat of bodily harm and has the ability to affect such harm.

- A. The decision to restrain shall be based on a current clinical assessment, and may also be based on other reliable information including information that was used to support the decision to take the individual into custody for treatment and evaluation. The fact that an individual is being evaluated or treated under Sections 27-65-105 through 27-65-109, C.R.S., shall not be the sole justification for the use of restraint.
- B. Mechanical restraints may be used only for the purpose of preventing such bodily movement that is likely to result in imminent injury to self or others. Mechanical restraint shall not be used solely to prevent unauthorized departure.
- C. Restraint of a single limb is not permitted, unless court-ordered or approved by the superintendent and the executive body of the secure treatment facility, utilizing the assessment standards set forth in Section 26-20-101, et seq., C.R.S.; Section 21.280.43, A, of these rules; and the secure treatment facility's policies.
- D. Restraint of an individual by a chemical spray is not permissible.
- E. The type of restraint shall be appropriate to the type of behavior to be controlled, the physical condition of the individual, the age of the individual and the type of effect restraint may have upon the individual.
- F. Restraint shall be applied only if alternative interventions have failed. Alternative interventions shall be documented in the clinical record; however, alternative techniques are not required if the alternatives would be ineffective or unsafe, when the individual is physically combative or actively assaultive or self-destructive.
- G. Justification for immediate use of restraint shall be documented in the clinical record.
- H. Restraint shall only be ordered by a Colorado licensed physician or psychologist.
- I. Restraint shall not be used for punishment, for the convenience of staff, or as a substitute for a program of care and treatment.
- J. Restraint does not include restraints used while the facility is engaged in transporting an individual from one facility or location to another facility or location within a facility when it is within the scope of that facility's powers and authority to effect such transportation pursuant to Section 26-20-101, et seq., C.R.S.

**21.280.44 Explanation to Individual [Eff. 11/1/13]**

In any situation, information shall be given to the individual, and guardian when applicable, as soon as possible after s/he has been secluded or restrained. The individual shall be given a clear explanation of the reasons for use of such intervention, the observation procedure, the desired effect, and the circumstances under which the procedure will be terminated. The fact that this explanation has been given to the individual shall be documented in the clinical record.

In an emergency situation, information given to the individual pursuant to this rule regarding the desired effect and the circumstances under which the procedure(s) will be terminated may not be as detailed as in a non-emergency situation. However, as the individual's condition improves, staff shall promptly supplement the information given and this shall be documented in the clinical record.

**21.280.45 Continued Use of Seclusion and/or Restraint [Eff. 11/1/13]**

- A. Staff shall document efforts to assure that the use of seclusion/restraint shall be as brief as possible.
- B. If the seclusion/restraint episode goes beyond one (1) hour, a Colorado licensed physician or psychologist must provide an order. A verbal order, including telephone or other electronic orders, may be used if followed by a written order by the Colorado licensed physician or psychologist.
- C. Seclusion and/or restraint shall not be ordered on an "as needed" basis.
- D. If the individual has not been examined by a Colorado licensed physician or psychologist within the previous twenty-four (24) hours, seclusion and/or restraint continued in excess of four (4) hours will require a face-to-face examination and a new written order by Colorado licensed physician or psychologist. If there has been a documented examination by a Colorado licensed physician or psychologist within the previous twenty-four (24) hours, seclusion/restraint continued in excess of fourteen (14) hours will require a face-to-face examination and a new written order by a Colorado licensed physician or psychologist prior to each succeeding twenty-four (24) hours of seclusion/restraint to assure that the need for these interventions is still present. The reasons for continuation shall be documented in the clinical record by the Colorado licensed physician or psychologist.
- E. An episode of seclusion/restraint is terminated when the individual has been out of seclusion/restraint for a continuous period of two (2) hours.
- F. Continued seclusion/restraint in excess of twenty-four (24) hours shall require an administrative review by the medical/clinical director of the facility or his/her designee, other than the Colorado licensed physician or psychologist in charge of treatment. The reviewer shall be an individual with the authority and knowledge necessary to review clinical information and reach a determination that the extension of a seclusion and/or restraint episode beyond twenty four (24) hours is clinically necessary.
- G. If the reviewer does not concur with the order for continuation of seclusion/restraint, the order shall be discontinued and the professional person in charge of treatment shall be notified of such discontinuation.
- H. An administrative review shall be initiated at the conclusion of each twenty four (24) hour period of continuous use of seclusion/restraint, and shall be completed prior to the expiration of each twenty four (24) hour period.

**21.280.46 Chart Documentation for the Use of Seclusion and/or Restraint [Eff. 11/1/13]**

- A. A staff member shall record each use of seclusion and/or restraint and the clinical justification for the use in the individual's chart. The justification shall include:
  - 1. The individual's specific behavior(s) and the nature of the danger;
  - 2. Describe attempts made to control the individual's behavior prior to using seclusion and/or restraint;

3. Describe the circumstances under which seclusion/restraint will be terminated and evidence that these criteria were given to the individual; and,
  4. Notification to a Colorado licensed physician or psychologist within one (1) hour of the seclusion/restraint intervention.
- B. Administrative review shall document the clinical justification for the continued use of seclusion/restraint in the individual's chart. The justification shall include:
1. Documentation that the professional person ordering the continuous use of seclusion/restraint in excess of twenty-four (24) hours has conducted a face-to-face evaluation of the individual within the previous twenty-four (24) hours.
  2. Documentation of the ongoing behaviors or findings that warrant the continued use of seclusion/restraint and other assessment information as appropriate.
  3. Documentation of a plan for ongoing efforts to actively address the behaviors that resulted in the use of seclusion/restraint.
  4. A determination of the clinical appropriateness of the continuation of seclusion/restraint.
  5. A summary of the information considered by the reviewer and the result of the administrative review with the date, time and signature of the individual completing the review.
- C. Information regarding use of seclusion/restraint shall be readily accessible to authorized individuals for review. Facilities shall have the ability to gather data as follows:
1. Each seclusion/restraint episode including date and time the episode started and ended, specific to each individual.
  2. Aggregated data to include total number of individuals secluded/restrained and average length of time of the episodes over the period of one year.

**21.280.47 Observation and Care [Eff. 11/1/13]**

- A. An individual who is in seclusion/restraint shall be observed in person by staff at least every fifteen (15) minutes, and such observation, along with the behavior of the individual, shall be recorded each time. Unless contraindicated by the individual's condition, such observation shall include efforts to interact personally with the individual.
- B. Ongoing provisions shall be made for nursing care, hygiene, diet and motion of any restrained limbs. For individuals in mechanical restraints, the facility shall provide relief periods, except when the individual is sleeping, of at least ten (10) minutes as often as every two hours, so long as relief from the mechanical restraint is determined to be safe. Staff shall note in the record relief periods granted. The individual shall have access to food at least every four (4) hours and shall have access to fluids and toileting upon request or during relief periods, but at least every two (2) hours, unless sleeping.
- C. Cameras and other electronic monitoring devices shall not replace the face-to-face observations.
- D. An individual in physical restraint shall be released from such restraint within fifteen (15) minutes after the initiation of physical restraint, except when precluded for safety reasons pursuant to Section 26-20-101, et seq., C.R.S.

- E. To the extent that the duties specified in Section 26-20-101, et seq., C.R.S. are more protective of individual rights, the provisions 26-20-101, et seq., C.R.S. shall apply.

**21.280.48 Facility Policies and Procedures for Seclusion/Restraint [Eff. 11/1/13]**

The facility shall have and shall implement written policies and procedures that describe the situations in which the use of seclusion and/or restraint are considered appropriate within each specific program and the staff members who can order their use. The policies and procedures shall include the requirements in Section 21.280.4 of these rules and Section 26-20-101, et seq., C.R.S.

In the event a facility does not authorize the use of seclusion and/or restraint of any type, the policy statement shall note the prohibition.

The policies and procedures shall include implementing administrative review including a process for terminating the seclusion and/or restraint episode when the reviewer does not concur with the order for continuation. If the reviewer is not a Colorado licensed physician or psychologist, then the order must be discontinued by a Colorado licensed physician or psychologist.

**21.280.5 THERAPY OR TREATMENT USING SPECIAL PROCEDURES**

**21.280.51 Informed Consent [Eff. 11/1/13]**

Therapies using stimuli such as electroconvulsive therapy (ECT), and behavior modifications using physically painful, aversive or noxious stimuli, require special procedures for consent and shall be governed by this rule.

- A. Prior to the administration of a therapy listed above, written informed consent shall be obtained and documented in the clinical record reflecting agreement by both the individual being treated and his/her legal guardian, if one has been appointed or alternative decision maker if one exists. If the individual undergoing treatment using special procedures is a child age sixteen (16) to eighteen (18), the clinical record shall reflect informed consent by both the child and his/her guardian(s).
- B. In the case of electroconvulsive therapy, a consent form prescribed by the Department shall be used and procedures set forth in Sections 13-20-401 through 13-20-403, C.R.S., shall be followed. An informed consent means:
1. It is freely and knowingly given and expressed in writing.
  2. That the following has been explained to the individual:
    - a. The reason for such treatment information;
    - b. The nature of the procedures to be used in such treatment, including their probable frequency and duration;
    - c. The probable degree and duration of improvement or remission expected with or without such treatment;
    - d. The nature, degree, duration, and probability of the side effects and significant risks of such treatment commonly known by the medical profession, the possible degree and duration of memory loss, the possibility of permanent irrevocable memory loss, and the remote possibility of death;

- e. The reasonable alternative treatments, if any, and why the Colorado licensed physician or psychologist is recommending the specific treatment;
  - f. That the individual has the right to refuse or accept the proposed treatment and has the right to revoke his consent for any reason at any time, either orally or in writing;
  - g. That there is a difference of opinion within the medical profession on the use of some treatments;
  - h. An offer to answer any inquiries concerning the recommended special procedures; and,
  - i. The number of treatments expected over a specified period of time to achieve maximum benefit.
3. The consent agreement entered into by the individual or other individual(s) shall not include exculpatory language through which the individual or other individual(s) is made to waive, or appear to waive, any of his/her legal rights, or to release the facility or any other party from liability for negligence.
  4. Informed consent for the special procedure shall be renewed each time the maximum number of treatments is given or the specified amount of time has expired. No informed consent for special procedures shall be valid for more than thirty (30) days.
  5. No one under the age of sixteen (16) shall undergo electroconvulsive treatment.
  6. Electroconvulsive treatment requires a concurring consultation by a licensed psychiatrist prior to administration of the treatment. Such consultation shall be noted in the clinical record.
  7. All provisions of Sections 13-20-401 through 13-20-403, C.R.S., shall be followed.

**21.280.52 Involuntary Treatment Using Special Procedures [Eff. 11/1/13]**

In the event the individual or the legal guardian refuses to or cannot consent, treatments referenced in Section 21.280.51 using special procedures shall be administered only under the following circumstances:

- A. With a prior court order for the treatments using special procedure; or,
- B. In an emergency in which the life of the individual is in imminent danger because of the individual's condition. In an emergency situation in which the individual is unable to grant informed consent and sufficient time does not exist to petition the court for an order prior to the administration of the specific therapy, the individual's physician, in consultation with the director of the facility or his/her designee, may, after careful and informed deliberation and under procedures adopted by the facility, order a special procedure without consent.

**21.280.53 Documentation of Special Procedures [Eff. 11/1/13]**

Along with the evidence of informed consent as delineated in this section, the reason for the use of any special procedure shall be fully documented in the individual's record. The administration and outcome of such special procedure shall also be documented in the clinical record.

**21.280.54      Procedures [Eff. 11/1/13]**

Each designated facility shall adopt written procedures for administration of special procedures in accordance with these rules and applicable statutes.

**21.280.6      CONTINUITY OF CARE [Eff. 11/1/13]**

Each facility shall adopt and implement a written policy for continuity of care. The policy shall include at a minimum the following:

- A.      Access to all necessary care and services within the facility, and coordination with any other current mental health care providers or other systems of care or support as appropriate.
- B.      Coordination of care with the individual's previous mental health care providers or medical providers as appropriate, including retrieval of psychiatric and medical records.
- C.      Coordination of the individual's care with family members, guardians and other interested parties as appropriate and in a manner that reflects the individual's culture and ethnicity.
- D.      The facility is not responsible for providing non-psychiatric medical care under these rules, but shall facilitate access to proper medical care and shall be responsible for coordinating mental health treatment with medical treatment provided to the individual.

**21.280.7      TRANSFER OF CARE AND TRANSPORTATION**

**21.280.71      Transfer of Care [Eff. 11/1/13]**

- A.      The individual shall only be transferred to another designated or placement facility when adequate arrangements for care by the receiving facility have been made and documented in the clinical record. Transfer coordination shall include at least one discharge planning conference, face-to-face or by telephone, with participants from both facilities and the individual and his/her guardian, whenever possible.
- B.      At least twenty-four (24) hours advance notice of transfer shall be given to individuals under certification, unless knowingly waived in writing by the individual and guardian as appropriate, except in cases of a medical emergency. Notice of such transfer shall also be provided to the court of competent jurisdiction and the individual's attorney.
- C.      The transferring facility shall ask the individual to indicate two (2) individuals to whom notification of transfer should be given and shall notify such individuals within twenty-four (24) hours of notification to the individual. Such notification shall be made by the transferring facility with the appropriate written authorization. Actions taken under this section shall be documented in the clinical record.

**21.280.72      Transportation [Eff. 11/1/13]**

Whenever transportation of an individual is required, the treating staff of the facility shall assess the individual for dangerousness to self or others and potential for escape. Whenever clinically and safely appropriate, the individual may be transported by other means such as ambulance, care van, private vehicle, and restraints shall not be used, unless authorized as necessary by the treating physician. If the treating staff assesses the individual as dangerous to self or others or as an escape risk, the staff may request transportation by the local Sheriff's Department.

- A.      A request for transportation from the Sheriff's Department shall be filed with the court of appropriate jurisdiction and shall include:
  - 1.      Statements from the treating Colorado licensed physician or psychologist supporting the need for transportation by the Sheriff's Department;
  - 2.      Recommendations concerning the use of mechanical restraints and the impact that handcuffs or shackles would have on the individual;
  - 3.      Recommendations for soft restraints, not handcuffs or shackles, if the findings of the assessment support the use of mechanical restraint;
  - 4.      Recommendations concerning the placement and management of the individual during the time s/he will be absent from the designated facility due to court hearings;
  - 5.      Recommendations of considerations for management of the individual based on the individual's age, physical abilities, culture, medical and psychiatric status and/or stability.
- B.      Notice of the request for transportation by the Sheriff's Department shall be given to the individual and his/her attorney at least twenty-four (24) hours prior to the time it is filed with the court. This notice shall not be required during the time a seventy-two hour hold is in effect or in an emergency situation with an individual under certification or when the individual signs a waiver which has been clearly explained.
- C.      Requesting transportation by the Sheriff's Department does not require a finding of dangerousness to self or others or an escape risk if the Sheriff's Department is willing to transport the individual without the use of mechanical restraints.

**21.280.8      CERTIFICATION FOR TREATMENT ON AN OUTPATIENT BASIS [Eff. 11/1/13]**

An individual who has been treated as an inpatient under a short-term or long-term certification for mental health treatment at a designated facility may be treated on an outpatient basis if the following conditions are met:

- A.      A Colorado licensed physician or psychologist who has evaluated the individual and who is on the staff of the designated facility which has been treating the individual, determines that while the individual continues to meet the requirements for certification, professional judgment is that with appropriate treatment modalities in place the individual is unlikely to act dangerously in the community.
- B.      Certification on an outpatient basis is the appropriate disposition suited to the individual's needs.
- C.      The designated facility that will hold the certification on an outpatient basis has documentation of the results of a recent physical examination.

- D. Arrangements have been made for the individual to have access to:
  - 1. Case management;
  - 2. Medication management;
  - 3. Essential food, clothing, shelter; and,
  - 4. Medical care and emergency dental care.
- E. The service plan shall reflect the outpatient certification status, the arrangements under D, 1-4, above, and meet the requirements in Sections 21.190.4 and 21.280.92 Service Planning.
- F. Content of the individual's outpatient record shall meet the requirements in Sections 21.190 and 21.280.9, Documentation in Individual Records.

**21.280.81 Enforcement of Certification [Eff. 11/1/13]**

- A. If the individual on outpatient certification substantially fails to comply with the requirements specified in his/her service plan, the Colorado licensed physician or psychologist or staff of the designated facility that holds the certification, shall make reasonable efforts, including outreach, to obtain the individual's compliance with the plan. As part of these efforts, reasonable attempts shall be made to advise the individual that s/he may be picked up and taken into custody for appraisal of the individual's need for continued certification and ability to receive treatment on an outpatient basis.
- B. If the designated facility's medical director or the treating Colorado licensed physician or psychologist reasonably believes that there is a significant risk of deterioration in the individual's condition or that the individual may pose a risk of harm to self or the community, and reasonable efforts to obtain the individual's compliance with the service plan have been unsuccessful, the medical director or the treating professional person shall make arrangements to have the individual transported to a designated facility or the emergency room of a hospital. The individual shall be assessed for current clinical needs and modifications made in legal status or treatment as necessary, including readmission to an inpatient facility.
- C. The individual shall not be physically forced to take prescribed psychiatric medication during this appraisal process, unless an emergency situation exists or the individual is court-ordered to do so as set forth in Section 21.280.33 through 21.280.36.
- D. Following the assessment, if the individual is not detained, the facility holding the certification shall arrange transportation for the individual to return to the individual's residence or other reasonable location, if the individual so desires.

**21.280.9 DOCUMENTATION IN INDIVIDUAL RECORDS**

**21.280.91 Assessment [Eff. 11/1/13]**

Records shall include:

- A. Assessment information in accordance with Section 21.190.3.
- B. Evidence of ongoing assessment that at a minimum shall be included in the monthly service plan review process.

- C. Evidence of an assessment update for continued certification every six months for individuals being treated under an outpatient certification or a long-term certification.

**21.280.92 Service Planning Requirements [Eff. 11/1/13]**

Service plans shall follow requirements in 21.190.4 (noting the exception in 21.280.92, G, below, of monthly service plan reviews), and:

- A. The service plan shall contain specific criteria required for discharge from treatment or to progress to less restrictive treatment alternatives.
- B. For individuals receiving care through outpatient certification, the plan shall assure the individual has access to medical and emergency dental care, case management, medication management, food, clothing, and shelter.
- C. If an individual is discharged during a seventy-two (72) hour hold without certification by the facility, and a service plan has not been completed, then pertinent information shall be included in the discharge summary.
- D. The facility shall appoint a clinical staff person to be responsible for the formulation, implementation, review, and revision of the service plan. The name of the responsible staff person shall be specified in the plan and that individual shall sign the plan. The plan shall also be signed by the treating Colorado licensed physician or psychologist, if he or she is not the responsible staff person.
- E. A physician or other professional person authorized by law to prescribe the medications shall be responsible for the component of the plan requiring medication management services.
- F. Service plans shall be readily identifiable and shall be maintained in a place readily accessible to treatment staff.
- G. The service plan shall be reviewed, and revised if necessary, at least monthly by the staff person responsible for the plan, the treating Colorado licensed physician or psychologist, the individual and the legal guardian. This review shall be documented in the record and include progress toward meeting the criteria for termination of treatment and the need for continued involuntary treatment if the individual is certified. If the monthly review is delayed, the reason for such delay shall be noted in the record and the review shall be completed as promptly as possible.

**21.280.93 Treatment Progress and Documentation Requirements [Eff. 11/1/13]**

Records shall contain treatment progress notes per Section 21.190.5 and the following:

- A. Documentation of all treatment procedures including, but not limited to: brief physical restraint, seclusion, mechanical restraint, medications voluntary and involuntary, and other therapies or interventions.
- B. Information regarding the serious injury of or by the individual and the circumstances and outcome.
- C. Documentation of all transfers and reasons for transfer.
- D. Legal status and all legal documents related to treatment under Section 27-65-101, et seq., C.R.S.
- E. Consultations and/or case reviews.

- F. Pertinent information from outside agencies or persons or from the individual.
- G. Correspondence to and from relevant agencies and individuals.
- H. Monthly documentation of the results of a Colorado licensed physician or psychologist's review of certification, effectiveness of mental health treatment, legal status of the individual and considerations of less restrictive treatment alternatives.
- I. Consent forms as appropriate for alternative treatments or voluntary treatment.
- J. Use or non-use of advance directives.

**21.280.94 Discharge Planning Requirements [Eff. 11/1/13]**

- A. Records shall include documentation that written information has been given to the individual upon discharge. This information shall include provision of Section 21.190.6, and:
  - 1. If the individual is being transferred to another facility, information regarding that transfer and the facility shall be included.
  - 2. Information if the discharge is being made against the advice of the treating Colorado licensed physician or psychologist.

**B. Discharge Summary**

Records shall contain a discharge summary to include the provisions of Section 21.190.62 and the following information:

- 1. A summary of treatment received including: involuntary treatments, advance directives, progress made, and case management activities.
- 2. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities, including mode of transportation.

**21.290 ACUTE TREATMENT UNITS**

**21.290.1 DEFINITIONS [Eff. 11/1/13]**

"Acute Treatment Unit" (ATU) means a facility or a distinct part of a facility for short-term psychiatric care, which may include substance use disorder treatment. An ATU provides a twenty-four (24) hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services, such as crisis management and stabilization services, than are available on an outpatient basis. The average lengths of services are from three (3) to seven (7) days.

"Auxiliary Aid" means any device used by individuals to overcome a physical disability and includes, but is not limited to, a wheelchair, walker or orthopedic appliance.

"Bedridden" means an individual who is unable to ambulate or move about independently or with the assistance of an auxiliary aid, who also requires assistance in turning and repositioning in bed.

"Director" means an individual who is responsible for the overall operation and daily administration, management, and maintenance of the facility.

“Emergency Contact” means one of the individuals identified on the face sheet of the individual record to be contacted in the case of an emergency.

“Facility” means an acute treatment unit.

“Licensee” means the individual or entity to whom a license is issued by the Colorado Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a), C.R.S., and certification as a 27-65 designated facility has been granted by the Department to operate a facility within the definition herein provided.

“Medical or Nursing Care” means care provided under the direction of a physician and maintained by on-site nursing personnel.

“Owner” means the entity in whose name the license and designation is issued. The entity is responsible for the financial and contractual obligations of the facility. “Entity” means any corporation, Limited Liability Corporation, firm, partnership, or other legally formed body, however organized.

“Personal services” means those services that the director and employees of an acute treatment unit provide for each individual including, but not limited to:

- A. An environment that is sanitary and safe from physical harm;
- B. Assistance with transportation whether by providing transportation or assisting in making arrangements for the individual to obtain transportation; and,
- C. Assistance with activities of daily living.

“Protective Oversight” means guidance as required by the needs of the individual or legal representative or as reasonably requested by the individual including the following:

- A. Being aware of an individual’s general whereabouts, although the individual may travel independently in the facility; and,
- B. Monitoring the activities of the individual on the premises to ensure the individual’s health, safety, and well-being, including monitoring the individual’s needs and ensuring that s/he receives the services and care necessary to protect health, safety, and well-being.

“Short-Term Psychiatric Care” means services that average from three to seven (3-7) days provided to individuals with mental health disorders in accordance with Title 27, Section 65, C.R.S.

## **21.290.2 DESIGNATION OF ACUTE TREATMENT UNITS [Eff. 11/1/13]**

Facilities applying for designation as an acute treatment unit (ATU) must be in compliance with Section 21.280 and the requirements in the following Subsections 21.290.21 through 21.290.58.

### **21.290.21 Director Minimum Education, Training and Experience Requirements [Eff. 11/1/13]**

Any individual serving as a director shall meet the minimum education, training, and experience requirements in one of the following ways:

- A. The director shall have received a Bachelor’s degree from an accredited college or university and have three years of verified experience in the human services field, one of which was in a supervisory or administrative position; or,

- B. The director shall have received a Master's degree from an accredited college or university and have two years of verified experience in the human services field, one of which was in a supervisory or administrative position.
- C. Training in the following areas:
  - 1. Individual rights;
  - 2. Environment and fire safety, including emergency procedures and First Aid;
  - 3. Assessment skills;
  - 4. Identifying and dealing with difficult situations and behavior management; and,
  - 5. Nutrition.

**21.290.22 Director Responsibilities [Eff. 11/1/13]**

The director shall be responsible for the following:

- A. Overall direction and responsibility for the individuals, program, facility, and fiscal management;
- B. Overall direction and responsibility for supervision of staff;
- C. The selection and training of a capable staff member who can assume responsibility for management of the facility in the director's absence; and,
- D. The establishment of relationships and maintaining contact with allied agencies, services, and mental health resources within the community.

**21.290.23 Assistant or Acting Director [Eff. 11/1/13]**

- A. In each facility, there shall be a specifically designated staff member, age twenty one (21) or over, capable of acting as a substitute for the director during his/her absence. The duties and responsibilities of the acting director shall be clearly defined in order to avoid confusion and conflict among other staff and individuals.
- B. If the director is regularly absent from the facility more than fifty percent (50%) of his/her working hours, an assistant director shall be appointed who meets the same qualifications as the director found at Sections 21.290.21.

**21.290.24 Administrative Coverage [Eff. 11/1/13]**

When there is a change in director, or when the director has left the facility permanently without a replacement, the facility shall notify the Department in writing, within twenty four (24) hours. When a possible change in director is anticipated, the facility shall notify the Department prior to the change.

Either the director or assistant or acting director shall be available at all times.

**21.290.25 Clinical Director [Eff. 11/1/13]**

- A. The clinical director is responsible for assuring that there is adequate training and supervision for staff.

**B. Qualifications of a Clinical Director**

1. The clinical director shall possess a Master's degree or Ph.D. in a mental health related field or a Bachelor's degree in a mental health related field and five (5) years of work experience.
2. Additionally, the clinical director shall receive training on:
  - a. Individual rights;
  - b. Environment and fire safety, including emergency procedures and First Aid;
  - c. Assessment skills; and,
  - d. Identifying and treating individuals who have received diagnoses from the most current diagnostic and statistical manual of mental disorders and who display behaviors that are common to people with severe and persistent mental health disorders.

**21.290.3 PERSONNEL**

**21.290.31 Physical or Mental Impairment [Eff. 11/1/13]**

Any individual who is physically or mentally unable to adequately and safely perform duties that are essential functions may not be assigned duties as a direct care staff member or volunteer at an ATU.

**21.290.32 Alcohol or Substance Use [Eff. 11/1/13]**

The facility shall not employ or allow any individual who is under the influence of a controlled substance, as defined in Sections 18-18-203, 18-18-204, 18-18-205, 18-18-206, and 18-18-207, C.R.S., or who is under the influence of alcohol in the workplace. This does not apply to employees using controlled substances under the direction of a physician and in accordance with their health care provider's instructions, as long as it does not pose a safety risk to the employee, other employees, or individuals.

**21.290.33 Access to Policies and Procedures [Eff. 11/1/13]**

- A.** The facility shall have a written statement of personnel policies that include:
1. Salary range and provisions for increases;
  2. Hours of work and holiday, vacation, sick and other applicable leave information;
  3. Conditions of employment, tenure and promotion;
  4. Employment benefits; including medical/dental/life insurance, workers compensation insurance, retirement plan, and any other available benefits;
  5. Employee performance evaluation procedures;
  6. Grievance procedures that may be used by staff; and,
  7. Discipline and/or termination procedures.
- B.** A copy of the personnel policy shall be given to each staff member at the time of his/her employment.

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**21.290.34 Specialized Training Requirements for ATU [Eff. 11/1/13]**

- A. In addition to the personnel training standards in Sections 21.160 and 21.280.24 for designated facilities, prior to providing direct care, the facility shall provide training on:
  - 1. First Aid and injury response;
  - 2. The care and services for the current individuals; and,
  - 3. The recognition and response to common side effects of psychiatric medications, and response to emergency drug reactions in accordance with facility policies.
- B. Within one month of the date of hire, the facility shall provide training for staff on each of the following topics:
  - 1. Assessment skills;
  - 2. Infection control;
  - 3. Behavior management and de-escalation techniques, to include incidents involving suicide, assault, or elopement.
  - 4. Health emergency response; and,
  - 5. Behavioral/psychiatric emergency response training.

**21.290.35 Staffing Requirements [Eff. 11/1/13]**

- A. The facility shall employ sufficient staff to ensure that the provision of services meets the needs of individuals. The facility shall maintain at least a one to six (1:6) trained staff member(s) to individual resident ratio at all times.
- B. In determining the staffing levels, the facility shall give consideration to factors including, but not limited to:
  - 1. Services to meet the individuals' needs; and,
  - 2. Services to be provided under the individual service plan.
- C. Each facility shall ensure that, at minimum, an individual qualified as described in Section 21.290.57 is available to administer medications at all times.
- D. Residents of the facility may volunteer in performing housekeeping duties and other tasks suited to the individual's abilities; however, these persons who provide services for the facility on a regular basis may not be included in the facility's staffing plan in lieu of facility employees.
- E. Volunteers may be utilized in the facility, but may not be included in the facility's staffing plan in lieu of facility employees.

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**21.290.4 POLICIES AND PROCEDURES FOR ATU**

**21.290.41 Emergency Plan and Fire Escape Procedures [Eff. 11/1/13]**

- A. Emergency plan: The emergency plan shall include planned responses to fire, gas explosion, bomb threat, power outages, and tornado. Such plan shall include provisions for alternate housing in the event evacuation is necessary.
- B. Fire escape procedures: The fire escape procedures shall include a diagram developed with local fire department officials which shall be posted in a conspicuous place.
- C. Within three (3) days of admission, emergency procedures, including the plan and diagram of fire exits, shall be explained to each individual.

**21.290.42 Serious Illness, Serious Injury, or Death [Eff. 11/1/13]**

- A. The policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of persons receiving services, including incident reporting requirements.
- B. The policy shall include a requirement that the facility notify an emergency contact when the individual's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately.

**21.290.43 Physical Health Assessment [Eff. 11/1/13]**

The facility shall develop policies and procedures that identify when a physical health assessment by a qualified licensed independent practitioner will be required, including the following indicators:

- A. Within twenty-four (24) hours of admission;
- B. A significant change in the individual's condition;
- C. Evidence of possible infection (open sores, etc.);
- D. Injury or accident sustained by the individual that might cause a change in the individual's condition;
- E. Known exposure of the individual to a communicable disease; or,
- F. Development of any condition that would have initially precluded admission to the facility.

**21.290.44 Smoking [Eff. 11/1/13]**

- A. Facilities' policies for smoking shall address individuals, staff, volunteers and visitors, and shall comply with applicable state laws and regulations.
- B. Prior to admission or employment, individuals and staff shall be informed of any prohibitions.

**21.290.45 Discharge [Eff. 11/1/13]**

- A. The facility's discharge policy shall include all of the following:
1. Circumstances and conditions under which the facility may require the individual to be involuntarily transferred or discharged;
  2. An explanation of the notice requirements;
  3. A description of the relocation assistance offered by the facility; and,
  4. The right to call advocates, such as the Governor's protection and advocacy for individuals with mental health disorders, the adult protection services of the appropriate county department of social or human services, and/or the Colorado Department of Human Services, Office of Behavioral Health.
- B. Disclosure to Individuals

Upon admission, the facility shall document that the individual or legal representative, as appropriate, has read or had explained the discharge policy.

**21.290.46 Management of Personal Funds and Personal Property [Eff. 11/1/13]**

The facility shall develop written policies that include the procedures for managing individual funds or property.

- A. Upon admission, a written inventory of all personal belongings shall be conducted. This inventory shall be signed and reviewed by facility staff and the individual, and shall be maintained in the individual's clinical record.
- B. All inventoried items shall be stored in a secure location during the individual's stay in the facility.
- C. All inventoried property shall be returned to the individual upon discharge. The individual and facility staff shall sign the inventory form indicating that all items were returned.

**21.290.5 ADMINISTRATIVE FUNCTIONS**

**21.290.51 Admissions [Eff. 11/1/13]**

- A. The facility shall develop written admission criteria based on the facility's ability to meet the individual's needs. Admission criteria shall be based upon a comprehensive pre-admission assessment of the individual's mental health, physical health, substance use, and capacity for self-care. The assessment shall determine the level of intervention and supervision required, including medication management, behavioral health services and stabilization prior to return to the community.
- B. Acute treatment units shall not admit individuals with a mental health disorder into a locked setting unless there is no less restrictive alternative and unless they are otherwise in compliance with the requirements of Title 27, Article 65, Colorado Revised Statutes.
- C. Individuals may be admitted to a locked setting as a voluntary or involuntary individual. If voluntary, the individual shall sign a form that documents the following information:
1. The individual is aware that the facility is locked.

2. The individual may exit the facility with staff assistance and/or permission.
  3. The individual may leave the facility at any point in time, unless he/she presents as a danger to self or others, or is gravely disabled as defined in Section 27-65-101, et seq., C.R.S.
- D. An individual who is imminently suicidal or homicidal shall only be admitted to the locked facility, upon completion of the facility's assessment and the facility's determination that the individual's safety and the safety of others can be maintained by the facility. If an individual is admitted and facility staff determine that his/her behavior cannot be safely and successfully treated at the ATU, then staff shall make arrangements to transfer the individual to the nearest hospital for further assessment and disposition.
- E. A facility shall not admit or keep any individual who meets the following exclusion criteria:
1. Is consistently incontinent unless the individual or staff is capable of preventing such incontinence from becoming a health hazard.
  2. Is under the age of eighteen (18).
  3. Is bedridden with limited potential for improvement.
  4. Has a communicable disease or infection that is:
    - a. Reportable under the Department of Public Health and Environment's regulations (6 CCR 1009-1 and 2); and,
    - b. Potentially transmittable in a facility, unless the individual is receiving medical or drug treatment for the condition and the admission is approved by a physician.
  5. Has acute withdrawal symptoms, is at risk of withdrawal symptoms, or is incapacitated due to a substance use disorder.
- F. Facilities shall not admit an individual diagnosed with a developmental disability unless he/she has a mental health disorder and has been diagnosed using the most current diagnostic and statistical manual of mental disorders, and whose behaviors can be managed and/or modified by facility staff during the designated length of stay, and whose behaviors will not endanger the safety of the individual, staff or other individuals.
- G. The facility shall maintain a current list of individuals and their assigned room.

**21.290.52 Acknowledgements and Disclosures [Eff. 11/1/13]**

There shall be written evidence of consent to treat as outlined in Section 21.170.4 and the following upon admission to the individual or individual's legal representative, as appropriate:

- A. Acknowledgements shall specify the understanding between the parties regarding, at a minimum:
1. Charges;
  2. Services included in the rates and charges;
  3. Types of services provided by the facility, those services which are not provided, and those which the facility will assist the individual in obtaining;

4. Transportation services;
5. Therapeutic diets;
6. A physically safe and sanitary environment;
7. Personal services;
8. Protective oversight;
9. Social and recreational activities; and,
10. A provision that the facility must give individuals thirty (30) calendar days' notice of closure.

**B. Disclosure to individuals shall include:**

1. Management of personal funds and property;
2. Facility rules, established pursuant to Section 21.290.53;
3. Staffing levels based on individual needs;
4. Types of daily activities, including examples of such activities that will be provided.

**21.290.53 Facility Rules [Eff. 11/1/13]**

The facility shall establish written policies, which shall list all possible actions that may be taken by the facility if any policy is knowingly violated by an individual. Facility policies may not violate or contravene any rule herein, or in any way discourage or hinder an individual's rights.

The facility shall prominently post its policies in writing, which shall be available at all times to individuals. Such policies shall address at least the following:

- A. Smoking;
- B. Cooking;
- C. Visitors;
- D. Telephone usage including frequency and duration of calls;
- E. Use of common areas, including the use of television, radio;
- F. Consumption of alcohol and/or illicit drugs;
- G. Dress;
- H. Pets, which shall not be allowed in the facility; however, in no event shall such rules prohibit service or guide animals.

**21.290.54 Content of Record [Eff. 11/1/13]**

Records shall include Section 21.190.2, Content of Records, and the following:

- A. Demographic and medical information;
- B. A cover sheet to contain the following information:
  - 1. Individual's full name, including maiden name if applicable;
  - 2. Individual's sex, date of birth, marital status and social security number, where needed for Medicaid or employment purposes;
  - 3. Individual's current address of residence;
  - 4. Date of admission;
  - 5. Name, address and telephone number of relatives or legal representative(s), or other individual(s) to be notified in an emergency;
  - 6. Name, address and telephone number of individual's primary physician, and case manager if applicable, and an indication of religious preference, if any, for use in emergency;
  - 7. Individual's diagnoses, at the time of admission;
  - 8. Current record of the individual's allergies;
- C. Medication administration record;
- D. Physician's orders.

**21.290.55 Service Planning [Eff. 11/1/13]**

The facility shall develop and implement a written service plan in accordance with Section 21.190.4 and include the following:

- A. An initial written safety and stabilization plan for each individual detailing risk issues and the stabilization process resulting in discharge shall be completed at the time of admission.
- B. Within twenty four (24) hours of admission, an individualized service plan for each individual shall be written and shall include, but not be limited to:
  - 1. Special dietary instructions, if any;
  - 2. Any physical or cognitive limitations; and,
  - 3. A description of the services which the facility will provide to meet the needs identified in the comprehensive assessment.
- C. The individual may request a modification of the services identified in the service plan at any time.

- D. The individual and his/her service plan shall be reassessed on an ongoing basis to address significant changes in the individual's physical, behavioral, cognitive and functional condition, and identify the services that the facility shall provide to address the individual's changing needs. The service plan shall be updated to reflect the results of the reassessment.

**21.290.56 Discharge [Eff. 11/1/13]**

- A. An individual shall be discharged for one or more of the following reasons:
1. When the facility cannot protect the individual from harming him or herself or others;
  2. When the facility is no longer able to meet the individual's identified needs;
  3. When the individual is no longer in need of this level of care; or,
  4. Failure of the individual to comply with facility rules, which contain notice that discharge may result from violation of same.
- B. Notice of discharge shall be provided to the individual or individual's legal representatives as follows:
1. At least twenty-four (24) hours in advance of discharge or transfer, in accordance with the rules governing the care and treatment of persons with a mental health disorder in Sections 21.280.7 and 21.280.8.
  2. In cases of a medical or psychiatric emergency, the emergency contact shall be notified as soon as possible.
- C. Discharge shall be coordinated with the individual, and, with permission, the individual's family, legal representative, or appropriate agency.

**21.290.57 Medication**

**21.290.571 Storage, Disposition, and Disposal [Eff. 11/1/13]**

- A. Storage and Disposition
1. All personal medication must be surrendered to the facility to be logged in and stored by the facility. Individuals are not allowed to self-administer medication in the facility.
  2. Personal medication shall be returned to the individual or individual's legal representative, upon discharge or death, except that return of medication to the individual may be withheld if specified in the individual's service if a physician or other authorized medical practitioner has determined that the individual lacks the decisional capacity to possess or administer such medication safely.
  3. Medications shall be labeled with the individual's full name, pursuant to Article 42.5 of Title 12.
  4. Any medication container that has a detached, excessively soiled or damaged label shall be returned to the issuing pharmacy for re-labeling or disposed of appropriately.
  5. All medication shall be stored in a manner that ensures the safety of all individuals.

6. Medication shall be stored in a central location, including refrigerators, and shall be kept under lock and shall be stored in separate or compartmentalized packages, containers, or shelves for each individual in order to prevent intermingling of medication.
  7. Individuals shall not have access to medication that is kept in a central location.
  8. Medications that require refrigeration shall be stored separately in locked containers in the refrigerator. If medication is stored in a refrigerator dedicated to that purpose, and the refrigerator is in a locked room, then the medications do not need to be stored in locked containers.
  9. Prescription and over the counter medication shall not be kept in stock or bulk quantities, unless such medication is administered by a licensed medical practitioner.
- B. Disposal
1. The return of medication shall be documented by the facility.
  2. Medication that has a specific expiration date shall not be administered after that date and shall be disposed of appropriately.

**21.290.572 Administration of Medication [Eff. 11/1/13]**

Facilities shall follow psychiatric medication standards as outlined in Section 21.280.32 and the following:

- A. To be qualified to administer medication, an individual shall be a licensed practical nurse, registered nurse, physician, physician's assistant, or pharmacist.
- B. Only a licensed nurse may accept telephone orders for medication from a physician or other authorized practitioner. All telephone orders shall be evidenced by a written and signed order and documented in the individual's record and the facility's medication administration record.
- C. These rules apply to medications and treatment which do not conflict with state law and regulations pertaining to acute treatment units and which are within the scope of services provided by the facility, as outlined in the individual agreement or the facility rules.
- D. The facility shall be responsible for complying with physician orders associated with the administration of medication or treatment. The facility shall implement a system that obtains clarification from the physician, as necessary and documents that the physician:
  1. Has been asked whether refusal of the medication or treatment should result in physician notification.
  2. Has been notified, where such notification is appropriate.
  3. Has provided documentation of such notification shall be made in the individual's clinical record.
  4. Coordinates with external providers or accepts responsibility to perform the care using facility staff.
  5. Trains staff regarding the parameters of the ordered care as appropriate.
  6. Documents the delivery of the care, including refusal by the individual, of the medication or treatment.

**21.290.58 Administration of Oxygen [Eff. 11/1/13]**

Individuals may administer oxygen, if the individual is able to manage the administration himself or herself and staff shall assist with the administration as needed for safety, when prescribed by a physician and if the facility follows appropriate safety requirements regarding oxygen herein.

- A. Oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other.
- B. Tank valves shall be closed except when in use.
- C. Transferring oxygen from one container to another shall be conducted in a well-ventilated room with the door shut. Transfer shall be conducted by a trained staff member or by the individual for whom the oxygen is being transferred, if the individual is capable of performing this task safely. When the transfer is being conducted, no individual, except for an individual conducting such transfer, shall be present in the room.
- D. Tanks and other oxygen containers shall not be exposed to electrical sparks, cigarettes or open flames.
- E. Tanks shall not be placed against electrical panels or live electrical cords where the cylinder can become part of an electric circuit.
- F. Tanks shall not be rolled on their side or dragged.
- G. Smoking shall be prohibited in rooms where oxygen is used or stored. Rooms in which oxygen is used shall be posted with a conspicuous "no smoking" sign.
- H. Tanks shall not be stored near radiators or other heat sources. If stored outdoors, tanks shall be protected from weather extremes and damp ground to prevent corrosion.

**21.300 LICENSING OF ADDICTION PROGRAMS USING CONTROLLED SUBSTANCES**

**21.300.1 DEFINITIONS [Eff. 11/1/13]**

"Addicted" or "addiction" means dependence upon a drug in the following manner:

- A. Psychological dependence upon a drug so that the user lacks the ability to abstain from taking or using the drug or experiences a compulsive need to continue its use; and,
- B. A tolerance to the effects of the drug which leads the user to require larger and more potent doses; and,
- C. Such physical dependence upon the drug that the user suffers withdrawal symptoms if the user is deprived of its dosage.

"Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means to the body of an individual.

"Approved Private Treatment Facility" means a private agency meeting the standards prescribed in Section 27-82-102(2), C.R.S., and approved under Section 27-82-103, C.R.S., and shall be referred to as "approved treatment facility".

“Approved Public Treatment Facility” means an agency operating under the direction and control of or approved by the Department and meeting standards prescribed in Section 27-82-102(3), C.R.S., and approved under Section 27-82-103, C.R.S., and shall be referred to as “approved treatment facility.”

“Compound” means to produce or create by combining two or more substances.

“Controlled Substance” means a drug whose general availability is restricted or any substance that is strictly regulated or outlawed because of its potential for abuse or dependence. Controlled substances include narcotics, stimulants, depressants, hallucinogens, and cannabis.

“Corrective Action” means a time limited remedial measure applied to agencies that are out of compliance during a two year licensing period.

“Critical Incident” means a significant event or condition, which may be of public concern, which jeopardizes the health, safety, and/or welfare of staff and/or individuals including individual deaths on or off agency premises and theft or loss of controlled substances prescribed for individuals and dispensed, administered, and/or monitored by licensed agencies.

“Department” means the Colorado Department of Human Services.

“Dispense” means to interpret, evaluate, and implement a prescription drug order or chart order, including the preparation of a drug for an individual in a suitable container appropriately labeled for subsequent administration to or use by an individual.

“Dispenser” means a practitioner who dispenses.

“Diversion” means the transfer of any controlled substance from a licit to an illicit channel of distribution or use.

“Individual” means any individual who receives a controlled substance for the purpose of addiction treatment or to treat withdrawal symptoms of an addiction.

“Maintenance Treatment” means the dispensing of a controlled substance, such as methadone or buprenorphine, at stable dosage levels for a period in excess of twenty one (21) days in the supervised treatment of an individual for opioid addiction.

“Medication Assisted Treatment” means any treatment for an addiction that includes giving a controlled substance for medical addiction detoxification or maintenance treatment, which may be combined with other treatment services including medical, and shall be combined in all circumstances with psychosocial services.

“Medical Detoxification” means the process through which a person who is physically dependent on alcohol, illicit drugs, prescription medications, or a combination of these substances is over a period of time withdrawn from the substances of dependence and the process may include the use of controlled substances to alleviate the symptoms of withdrawal under the supervision of a licensed practitioner.

“Physical Dependence” means a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

“Practitioner” means:

- A. A physician or other person licensed, registered or otherwise permitted to distribute, dispense, or to administer a controlled substance in the course of professional practice.

- B. A pharmacy, hospital or other institution licensed, registered, or otherwise permitted to distribute, dispense, or to administer a controlled substance in the course of its professional practice in this state.

“Ultimate User” means an individual who lawfully possesses a controlled substance for the individual's own use or for the use of a member of the individual's household.

**21.300.2 CONTROLLED SUBSTANCE LICENSE REQUIREMENTS [Eff. 11/1/13]**

Approved agencies shall obtain a controlled substance license if they dispense, compound, or administer (pursuant to Section 27-80-204, C.R.S.) a controlled substance in order to treat an addiction or to treat the withdrawal symptoms of an addiction. All applicants for a controlled substance license shall demonstrate compliance with these rules and all applicable state and federal statutes and regulations including, but not limited to those pertaining to controlled substances.

**21.300.21 Licensing Procedures [Eff. 11/1/13]**

Treatment facilities meeting all the requirements of Colorado Revised Statutes Title 12, Article 42.5, Part 1; Title 18, Article 18, Part 3; Section 27-82-103, C.R.S.; the requirements of the controlled substance license rules; and, all applicable state and federal regulations including those that apply to controlled substances shall be issued a controlled substance license.

- A. A controlled substance license issued by the Department shall be obtained annually for each approved treatment facility that dispenses, compounds, or administers a controlled substance to treat addiction or the withdrawal symptoms of an addiction.
- B. A separate controlled substance license is required for each approved treatment facility site where controlled substances are dispensed, compounded, or administered, in order to treat addiction or the withdrawal symptoms of an addiction.
- C. Any approved treatment facility that receives a controlled substance license may dispense, compound, or administer controlled substances only to the extent authorized by their license and in conformity with Colorado Revised Statutes Title 12, Article 42.5, Part 1 and Title 18, Article 18.
- D. Routine monitoring: controlled substance licensing visits shall be scheduled and conducted by the Department during the approved agencies' normal business hours to the extent possible.
- E. The Department shall conduct unscheduled site visits for specific monitoring purposes and investigation of complaints or critical incidents involving approved agencies that have a controlled substance license. These unscheduled visits shall be in accordance with the:
1. Controlled substance license rules;
  2. Department policies and procedures;
  3. Department substance use disorder treatment rules;
  4. Any statutes and regulations that protect the confidentiality of individual identifying information.
- F. The Department shall have access to all individual, agency, and staff records and any other relevant documentation required to determine compliance with these rules and to coordinate individual placement and care.

- G. No controlled substance license shall be granted to any practitioner who has been convicted within the last two (2) years of a willful violation of Title 12, Article 42.5, Part 1 of the Colorado Revised Statutes or any other state or federal law regulating controlled substances.

**21.300.22 Initial License [Eff. 11/1/13]**

Applicants for an initial controlled substance license to dispense, compound, or administer controlled substances to treat an addiction or to treat the withdrawal symptoms of an addiction shall submit a controlled substance license application that has been affirmed and signed by a physician, a copy of current policies and procedures addressing the use of controlled substances to treat addiction or withdrawal symptoms of an addiction, and the application fee of two hundred and seventy five dollars (\$275).

- A. No approved treatment facility that is required to be licensed shall engage in any activity for which a controlled substance license is required until the facility's application is granted and a license is issued to the facility by the Department.
- B. Initial controlled substance license applications received by the Department that are not completed according to instructions, do not include the application fee, or do not include the required policies and procedures shall be returned to the applicant by certified mail with the submitted application fee and a written explanation as to why their application is being returned.
- C. The Department shall review complete initial applications that have the required fee and appropriate policies and procedures and the Department shall conduct an on-site inspection to determine that the applicant is in compliance with these controlled substance license rules, treatment rules, and all state and federal statutes and regulations.
- D. Initial applicants that are in full compliance shall be granted a controlled substance license that shall remain in effect for one (1) year from the date the license is issued.
- E. An applicant for licensure pursuant to these rules and regulations shall also be considered an applicant for registration pursuant to Section 18-18-302, Colorado Revised Statutes.
- F. Initial applicants that are found not to be in full compliance shall have their license applications returned by certified mail with a written explanation as to why their application is being returned and notification that their controlled substance license application has been denied as of ten (10) days from the date the letter was mailed. Application fees shall not be refunded. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.300 of these rules.

**21.300.23 License Renewal [Eff. 11/1/13]**

A controlled substance license shall expire one year from the date the license is granted.

- A. Agencies wishing to continue their controlled substance license shall submit a license renewal application affirmed and signed by a physician to the Department thirty (30) days prior to the expiration date of their current controlled substance license along with the required fee of two hundred and seventy-five dollars (\$275). A copy of the licensee's current controlled substance policies and procedures shall also be submitted with each annual renewal application.
- B. Any treatment facility that currently has a controlled substance license issued by the Department may not apply for renewal more than sixty days before the expiration date of the current controlled substance license.

- C. A controlled substance license renewal application that is received by the Department after the expiration date of the current license shall be returned to applicant by certified mail with submitted application fee and written notification that the licensee's controlled substance license is no longer in effect as of ten (10) days from the date the letter was mailed. An applicant may re-apply for an initial license in accordance with Section 21.300 of these rules.
- D. A controlled substance license renewal application that is received by the Department on or before the current licenses' expiration date shall be reviewed and on-site inspections may be conducted to determine that the licensee is in compliance with all controlled substance license rules.
- E. A licensee that is in full compliance shall be granted renewal of their annual controlled substance license that shall be effective for one year from the prior expiration date.
- F. Licensees not in full compliance shall have their applications for renewal of their controlled substance license denied. The licensee shall receive by certified mail written notification as to why the license was denied and notification that their current controlled substance license is no longer in effect as of ten (10) days from the date the letter was mailed. If an applicant disagrees with the decision, s/he may appeal (see Section 21.105); or upon remedying the noted deficiencies, may re-apply for an initial license in accordance with Section 21.300 of these rules.

**21.300.24 License Denial, Revocation, or Suspension [Eff. 11/1/13]**

- A. A controlled substance license may be denied, suspended, or revoked in accordance with Section 21.120.8 and upon finding that the licensee:
  - 1. Is not in compliance with the controlled substance license rules;
  - 2. Has violated any provision of Title 12, Article 42.5, Part 1, and Title 18, Article 18 of the Colorado Revised Statutes;
  - 3. Has failed to implement the Department imposed corrective actions;
  - 4. Has been negligent resulting in risk to individual and/or staff health or safety;
  - 5. Has failed to provide for adequate supervision of treatment staff as outlined in addiction counselor certification and licensure standards (Section 21.330);
  - 6. Has furnished false or fraudulent information in an application;
  - 7. Has, as a practitioner, been convicted of, or has had accepted by a court a plea of guilty or *nolo contendere* to a felony under any state or federal law relating to a controlled substance;
  - 8. Has had their federal registration to manufacture, conduct research on, distribute, or dispense a controlled substance suspended or revoked.
- B. The Department may limit revocation or suspension of a controlled substance license to the particular controlled substance, which was the basis for revocation or suspension.

- C. If the Department denies, suspends or revokes a controlled substance license, all controlled substances owned or possessed by the licensee at the time of the denial or suspension or on the effective date of the revocation order may be placed under seal. No disposition may be made of substances under seal until the time for making an appeal has elapsed or until all appeals have concluded unless a court orders otherwise or orders the sale of any perishable controlled substances and the deposit of the proceeds with the court. Upon a revocation order's becoming final, all controlled substances may be forfeited to the state.
- D. The Department shall promptly notify the Drug Enforcement Administration and the appropriate professional licensing agencies, if any, of all charges and the final disposition thereof and of all forfeitures of a controlled substance.

**21.300.3 MEDICATION ASSISTED TREATMENT PROVISIONS [Eff. 11/1/13]**

**A. Agency Policies and Procedures**

Agencies shall develop and implement policies and procedures, as defined in this section that address the use of controlled substances in the treatment of addiction or the withdrawal symptoms of an addiction. These policies shall include, but are not limited to, how individuals are assessed to be appropriate to receive a controlled substance to treat their addiction or the withdrawal symptoms of an addiction. These policies shall meet the requirements of all federal, state, and local laws pertaining to controlled substances.

- B. Medication assisted treatment using a controlled substance shall be provided to individuals who are physically dependent on alcohol, illicit drugs, prescription medications, or a combination of these substances to alleviate the individual's physical withdrawal symptoms and cravings, to help stabilize behavior, to increase productivity, and to reduce the risk of contracting and transmitting infectious diseases.
- C. Approved agencies shall only dispense, compound, or administer, controlled substances by or on the order of a physician who currently possesses and maintains a license to practice medicine in the State of Colorado as provided by Article 36, Title 12, C.R.S. The physician's medical order shall be documented in the individual's treatment record.
- D. Approved agencies that dispense, compound, or administer, controlled substances must also have a current registration from the Drug Enforcement Administration.
- E. All controlled substances shall be dispensed, compounded, or administered, according to applicable state and federal statutes, regulations, and rules, controlled substance license rules, and Department rules.
- F. Controlled substances shall be dispensed, compounded, or administered, in accordance with the manufacturer's specifications found on product labels and/or in printed instructions accompanying the product.
- G. Licensees shall maintain an individual dispensing record on each individual that receives controlled substances at their facility. The dispensing record shall include:
  - 1. Complete name of individual receiving the controlled substance;
  - 2. Name of the controlled substance, strength, and dosage form;
  - 3. Amount consumed;
  - 4. Amount dispensed;

5. Date dispensed;
  6. Amount and dosage form taken home by individual (if applicable);
  7. First initial and last name and the credentials of the individual who dispensed the controlled substance medication.
- H. Licensees shall ensure that all personnel are working within their scope of practice and shall only allow licensed medical personnel to dispense, compound, or administer, controlled substances.
- I. Each approved treatment facility shall provide formal training and testing on an annual basis to all employees on the Department's rules, the pharmacology of the substances dispensed and state and federal requirements especially around confidentiality.
- J. Critical Incident Reporting

In addition to the provisions of Section 21.140 a critical incident includes theft, loss, or diversion of a controlled substance shall also be considered a critical incident and the Department critical incident reporting policy shall be followed. The Department must be notified verbally within twenty four hours of the critical incident and a written report must be submitted to the Department within three (3) business days.

**21.300.4 MEDICAL EVALUATIONS [Eff. 11/1/13]**

Individuals who wish to receive medication assisted treatment shall have medical evaluations conducted by a physician, physician's assistant, or nurse practitioner to determine physical dependence and to determine that such individuals are appropriate for treatment with a controlled substance. Evaluations shall include, but are not limited to:

- A. A medical history that includes a detailed and comprehensive account of substance use history that includes all substances of abuse;
- B. Evidence of current physiological dependence; and,
- C. A pregnancy screen for females of childbearing age.

**21.300.5 INFORMED CONSENT [Eff. 11/1/13]**

All individuals receiving medication assisted treatment shall sign informed consent that they are voluntarily agreeing to treatment with a controlled substance. The individual shall be informed of what controlled substance they are receiving and the expected benefits and risks of medication assisted treatment. All individuals receiving controlled substances must also be informed of the risks of using other substances in combination with a controlled substance.

**21.300.6 SECURITY CONTROLS AND OPERATING PROCEDURES [Eff. 11/1/13]**

All licensees must follow the standards of physical security controls and operating procedures required by the federal Drug Enforcement Administration necessary to prevent diversion as outlined in Title 21, Food and Drugs, Chapter ii, Code of Federal Regulations, Sections 1301.71 through 1301.76; no later editions or amendments are incorporated. These regulations are available from the U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, 2401 Jefferson Davis Highway, Alexandria, VA 22301; or, the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236; or at any state publications depository library.

**21.300.7 RECORD KEEPING [Eff. 11/1/13]**

Licensees shall follow the record keeping requirements of the federal Drug Enforcement Administration, Code of Federal Regulations (Title 21, Food and Drugs, Part 1304) to ensure compliance with the requirements in Title 12, Article 42.5, Part 1, C.R.S.; no later editions or amendments are incorporated. These regulations are available from the U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, 2401 Jefferson Davis Highway, Alexandria, VA 22301; or the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236; or at any state publications depository library.

Licensees shall also keep inventories, records, and reports that are required by any other state or federal law or standard regulating controlled substances.

**21.300.8 HANDLING AND STORAGE [Eff. 11/1/13]**

All licensees shall have adequate and proper facilities for the handling and storage of controlled substances. All licensees must maintain proper control over such controlled substances to ensure against their being illegally dispensed or distributed. Access to the storage area shall be restricted to individuals specifically authorized to handle controlled substances. This includes restricting the number and accessibility of keys or passwords.

Licensees shall also develop and implement policies on how controlled substances will be obtained, stored, and accounted for. These policies shall include, but are not limited to:

- A. What controlled substance the licensee will be using for the addiction they are treating and how these controlled substances will be dispensed, compounded, or administered, as well who will be responsible for ordering the controlled substances;
- B. Where the controlled substances will be stored;
- C. How the controlled substances will be accounted for; and,
- D. Who will have access to the controlled substances.

**21.300.9 TOXICOLOGY SCREENING REQUIREMENTS [Eff. 11/1/13]**

Licensees shall develop and implement toxicology screen policies and procedures that specify a random sample collection protocol and these policies shall include, but not be limited to:

- A. How appropriate and approved samples for drug testing shall be collected and analyzed in accordance with applicable state and federal statutes and regulations.
- B. How toxicology screens shall be used to detect the presence of the approved controlled substance, that is being dispensed, and its metabolite, for which laboratory analyses are available.
- C. How all individuals entering medication assisted treatment shall provide a toxicology screen at time of admission and then at least one random toxicology screen per month which test for the presence of all substances of abuse, including alcohol and marijuana.
- D. How a licensee shall address an individual having illicit substances in a toxicology screen, including unauthorized prescription medications.
- E. How the licensee will have the ability to observe sample collection by appropriate personnel to help minimize falsification.

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**21.310 MEDICALLY MONITORED INPATIENT DETOXIFICATION**

**21.310.1 GENERAL PROVISIONS [Eff. 11/1/13]**

Medical detoxification services shall be provided by licensed medical staff qualified to supervise withdrawal from alcohol and other drugs through use of medication and/or medical procedures in residential or outpatient settings which possess controlled substances licenses in compliance with Colorado Revised Statutes Title 12, Article 42.5, Part 1.

**21.310.2 ADMISSION AND EVALUATION [Eff. 11/1/13]**

- A. Specific admission criteria shall be developed and implemented that detail for which drugs, including alcohol, medical detoxification is provided.
- B. Informed consent to medical detoxification shall include:
  - 1. Medications to be used;
  - 2. Need to consult with primary care physicians.
- C. Medical evaluations by physicians licensed pursuant to Article 36, Title 12, Colorado Revised Statutes Medical Practice Act, or authorized health-care professionals under the supervision of authorized physicians shall be required and shall consist of, at minimum:
  - 1. Medical histories including detailed chronologies of substance use disorders;
  - 2. Identification of current physical addiction including drug types;
  - 3. Physical examinations to determine appropriateness for outpatient or inpatient medical detoxification;
  - 4. Appropriate laboratory tests including pregnancy tests, and other evaluations as indicated.
- D. Protocols for usual and customary detoxification from each drug delineated in admission criteria shall be developed in consultation with licensed physicians and other allied health-care professionals and shall be implemented in the form of individualized detoxification plans under direct supervision of program medical directors. Protocols shall include:
  - 1. Types of intoxication;
  - 2. Tolerance levels for the individual's drug of choice;
  - 3. Degrees of withdrawal;
  - 4. Possible withdrawal and/or intoxication complications;
  - 5. Other conditions affecting medical detoxification procedures;
  - 6. Types of medications used;
  - 7. Recommended dosage levels;
  - 8. Frequency of visits (outpatient settings);

9. Procedures to follow in the event of detoxification complications;
  10. Daily assessments including expected improvements as well as potential problems;
  11. Expected duration of detoxification.
- E. Medical detoxification programs using any controlled substances are required to have controlled substance licenses issued by the Department. Buprenorphine is the only medication that can be used for opioid dependent individuals unless the medical detoxification program is licensed as an opioid treatment program and it has been verified through the program and coordinated with the CSA.
- F. Authorized physicians may prescribe buprenorphine under his/her own Drug Enforcement Administration (DEA) registration number for individuals admitted to hospital for inpatient detoxification or addiction treatment.

**21.310.3 CLINICAL STAFF [Eff. 11/1/13]**

- A. The following minimum clinical staff shall be provided:
1. One medical director;
  2. One R.N. or L.P.N. with at least one year of detoxification experience;
  3. Clinicians holding Colorado addiction counselor certifications at Levels II or III, or Colorado addiction counselor licenses, or appropriately credentialed per Section 21.330.
- B. Medical directors' responsibilities shall include, at minimum:
1. Quarterly reviews and revisions of drug detoxification categories and protocols;
  2. Reviews of individual detoxification plans;
  3. Reviews of individual prescriptions that deviate from standard detoxification protocols;
  4. Five hours minimum of monthly supervision of and consultation with staff providing detoxification services;
  5. Direct supervision of individual detoxification cases that deviate from standard protocols and/or experience complications;
  6. Developing and implementing back-up systems for physician coverage when medical directors are unavailable and/or for emergencies.
- C. There shall be twenty four (24) hour access to clinical staff by telephone and accommodation for unscheduled visits for crises or problem situations.

**21.310.4 TREATMENT SERVICES [Eff. 11/1/13]**

- A. The following treatment services shall be provided in addition to medication dosing contacts:
1. Motivational counseling and support;
  2. Continuous evaluation and behavioral health intervention.

3. Development and monitoring of a service plan per Section 21.190.4.
- B. There shall be a minimum of one (1) daily clinical supportive services contact, which shall be documented in individual records.

**21.310.5 DISPENSING AND ADMINISTRATION PROCEDURES [Eff. 11/1/13]**

- A. There shall be procedures for dispensing medications per standard detoxification protocols that are in accordance with applicable state and federal statutes and for the following:
1. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location;
  2. Individual prescriptions from medical directors that are filled from stock quantities.
- B. There shall be procedures in accordance with applicable federal and state statutes for storing and accounting for all drugs including controlled substances.

**21.320 OPIOID MEDICATION ASSISTED TREATMENT (OMAT)**

**21.320.1 DEFINITIONS [Eff. 11/1/13]**

“Administrative Discharge” means a process where it has been determined that a person in OMAT is unsafe and immediately needs to be discharged immediately. The timeframe for this is determined by the memorandum of understanding and typically involves a taper at a rate set forth by the program.

“Administrative Transfer” means a process whereby a person in OMAT is determined unsafe or has violated a behavioral agreement and a program is looking to transfer to another clinic of the persons’ choice. This person is to be transferred at a time frame that is determined by the memorandum of understanding and in agreement with the other programs.

“Courtesy Dosing” is known nationally as “Guest Dosing”, which means a process where a person in OMAT may be able to dose at another clinic; either in the state, or out of state to maintain the continuity of care for their OMAT. There is typically a fee charged and a specific process set up by the host clinic with receiving clinic in order to do this.

“Dilute Urinalysis” for the purposes of these rules means a creatinine level less than twenty (20) milligrams.

“Lock In” means a process where a program along with the State authority determine that a person is best served clinically at one program. This determines where the person is to go for their OMAT treatment.

“Lock Out” means a process where a program along with the State authority determine that it is in a person’s best interest to be locked out of a program due to concerns of this person not being safe to themselves or others in a program and/or could be a threat to that program due to diversion or other items.

“OMAT” means Opioid Medication Assisted Treatment.

“Special Exception Requests” are requests that must be sent to the state controlled administrator for final approval. These requests are for take home bottles above and beyond what is allowed for the person who is on Methadone at the time of the request.

“Take-Out Bottle” is a prescription of individually labeled bottle of Methadone that is determined allowed for each particular phase of treatment. Each bottle is labeled with proper required DEA information.

“Taper” refers to when an individual is being reduced on his/her dose for any reason either of their own accord or due to concerns that the medical director raises. Tapers are started with a medical order and monitored by the medical staff.

“Torsades de Pointe” or simply Torsades, is a French term that literally means “twisting of the spikes.” It refers to a specific, rare variety of ventricular tachycardia that exhibits distinct characteristics on the electrocardiogram (ECG).

“Transfer” is when an individual transfers from one program to another without a break in treatment.

**21.320.2 GENERAL PROVISIONS [Eff. 11/1/13]**

- A. Opioid Medication Assisted Treatment (OMAT) programs shall be provided to individuals meeting criteria for opioid dependence according to the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), 2000 edition; no amendments or later editions are incorporated. A copy is available for inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library.
- B. Agencies applying to be licensed as an opioid medication assisted treatment (OMAT) program shall have the following:
  - 1. Controlled substance use disorder license;
  - 2. Federal accreditation; and,
  - 3. DEA registration.
- C. Pregnant women receiving methadone or other approved controlled substances from an agency licensed to provide opioid medication assisted treatment shall not be detoxified during pregnancy without the approval of either the Department’s Controlled Substance Administrator/State Methadone Authority or the Office of Behavioral Health’s Women’s Treatment Coordinator.
  - 1. Pregnant women who are opioid dependent shall be referred to an agency licensed to provide OMAT, unless the original referring agency is also licensed for OMAT.
  - 2. The relationship between the referring agency and the agency providing OMAT shall be delineated in a written memorandum of understanding.
  - 3. The referring agency may not transfer responsibility for other aspects of the individual’s treatment to the agency providing OMAT unless this is clinically indicated and documented and the OMAT agency is also licensed for women’s gender-specific treatment.

**21.320.3 ADMINISTRATIVE AND MEDICAL RESPONSIBILITY**

**21.320.31 OMAT Program Sponsors [Eff. 11/1/13]**

OMAT program sponsors are responsible for the following:

- A. Overall operation of the program including, but not limited to:
  - 1. Compliance with all applicable state and federal laws, rules, and regulations;
  - 2. Medical and counseling personnel are qualified to provide opioid replacement treatment;
  - 3. Individuals are enrolled on their own volition;
  - 4. Full disclosure is made to individuals about opioids and their use in treatment.
  - 5. Written, informed consents for opioid replacement treatment are signed by individuals eighteen (18) years of age and older;
  - 6. Written, informed consents for all aspects of opioid replacement treatment are signed by parents, legal guardians or other responsible adults designated by appropriate state authorities for individuals under age eighteen (18) years old;
  - 7. Individual/counselor ratios do not exceed fifty to one (50:1) for full-time counseling staff, forty (40) hours per week, and twenty five to one (25:1) for half-time counseling staff, twenty (20) hours per week;
  - 8. Written (OMAT) policies and procedures are developed, implemented and maintained that are based on and in compliance with Department rules;
  - 9. All reasonable and clinically indicated efforts are made to coordinate treatment with other healthcare and behavioral health providers. Documentation includes obtaining individuals' consent to release information to communicate with those practitioners.
  - 10. Methadone and other controlled substances are disposed of in accordance with the federal regulations.
  - 11. Printed acknowledgements are signed by patients and kept in patient records stating that they have been informed of the United States Department of Transportation regulation against the use of OTP prescribed methadone by commercial drivers and the possible loss of commercial driver's license if taking methadone for addiction is discovered.
- B. Training
  - 1. Training for new (OMAT) staff is documented in personnel records including, but not limited to provisions of Section 21.160.1, A, 3, and:
    - a. Federal Opioid Medication Assisted Treatment regulations;
    - b. OMAT treatment rules;
    - c. OMAT policies and procedures;

- d. Clinical practices including, but not limited to:
    - 1) Protocols around special exception requests, phase level requests, and any take-home protocol such as holiday dosing, weekend dosing, hold doses, hospitalization of individuals, incarceration, nursing home stays, and courtesy dosing; and,
    - 2) All other items agreed upon in the State Memorandum of Understanding.
  - e. Pharmacology of methadone including, but not limited to, loss of tolerance to opioids, dangerous drug or alcohol interactions, signs and symptoms of overdose, purpose of its use.
2. Annual training for OMAT staff including, but not limited to:
- a. Most current pharmacology of medications used, and clinical practices applicable to OMAT, including problems with interactions of medications.
  - b. Review of federal and state regulations and rules.
  - c. Review of current OMAT policies and procedures.
  - d. Infectious disease risks and screening.

**21.320.32 OMAT Medical Directors [Eff. 11/1/13]**

- A. Agencies shall have designated medical directors who shall authorize and oversee other physicians, other appropriately licensed and/or certified medical personnel and all medical services provided.
- B. Medical directors and other medical healthcare providers shall currently possess and maintain licenses to practice medicine/nursing in compliance with the credentialing requirements of their own profession in Colorado as provided by Article 36, Title 12, C.R.S. OMAT medical directors shall assure appropriate credentials and training for other OMAT physicians and other qualified health care providers to deliver ORT.
- C. Medical directors shall ensure that the OMAT agency is in compliance with all state and federal rules and regulations regarding medical treatment for opioid addiction.
- D. OMAT medical directors, other OMAT physicians and authorized OMAT medical personnel shall ensure the following:
  - 1. Medical evaluations including evidence of current physiological dependence and/or history of addiction or exceptions to admission criteria that are documented prior to initial dosing;
  - 2. These medical evaluations are done at admission prior to initial dose.
  - 3. The physical examinations and all appropriate laboratory tests are performed and reviewed within fourteen (14) calendar days following treatment admission;
  - 4. All medical professionals shall educate individuals regarding risks and benefits of OMAT and document that individuals are entering voluntarily.

5. All medical orders are properly signed or countersigned including initial orders for approved controlled substances and other medications, subsequent dose increases or decreases, changes in take-home dose privileges, emergency situations and other special circumstances by the medical director.
- E. Medical directors or other physicians shall review, countersign and date intake evaluations written by authorized medical personnel before initial doses may be administered to individuals. When medical directors and other physicians are not available on-site to review, countersign and date evaluations for admission written by medical personnel, required physician reviews may be conducted by telephone and initial doses may be administered to individuals on physicians' verbal or standing orders. In such cases, medical personnel shall document in individual records that no physicians were available on site and that physician reviews were conducted by telephone. Medical directors or other physicians shall review and countersign authorizations.
- F. Medical directors and other qualified health care professionals shall utilize the information obtained from the Colorado State Board of Pharmacy's electronic Prescription Drug Monitoring Program (PDMP) as clinically appropriate upon intake.

**21.320.4 INDIVIDUAL PLACEMENTS**

**21.320.41 Admission Criteria and Procedures [Eff. 11/1/13]**

- A. Agencies shall follow all federal requirements in accordance with 42 CFR Part 8; no amendments or later editions are incorporated. A copy is available for inspection at the Colorado Department of Human Services, Office of Behavioral Health, Director of Community Programs, 3824 W. Princeton Circle, Denver, CO 80236; or any state publications depository library.
- B. Individuals shall be admitted to opioid medication assisted treatment if OMAT medical directors or other OMAT physicians determine, and subsequently document in individual records, that such individuals are currently physiologically dependent on opioid drugs or were physiologically dependent on opioid drugs, continuously or episodically for most of the year immediately preceding admission.
- C. In the case of individuals for whom the exact date on which physiological dependence began cannot be ascertained, OMAT medical directors or other OMAT physicians may, using reasonable clinical judgment, admit such individuals to opioid replacement treatment if from the evidence presented and recorded in individual records it is reasonable to conclude that such individuals were physiologically dependent on opioid drugs approximately one year prior to admission.
- D. OMAT medical directors or other OMAT physicians may waive the one-year history of addiction requirement, if clinically appropriate, for the following:
  1. Persons released from penal institutions if admitted to treatment within six (6) consecutive months following release;
  2. Pregnant individuals, if OMAT physicians certify pregnancy;
  3. Former persons receiving treatment for up to two (2) consecutive years after discharge.
- E. Persons under age eighteen (18) shall have at least two unsuccessful attempts at short-term detoxification or drug-free treatment documented within a twelve-month period.
- F. OMATs offering short-term or long-term detoxification treatment shall follow all applicable state and federal laws, rules and regulations regarding admission criteria.

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- G. OMATs shall not admit persons for more than two (2) detoxification treatment episodes per year.
- H. At time of admission, individuals shall be oriented to OMAT policies and procedures including, but not limited to:
1. Benefits and risks of opioid replacement treatment.
  2. Fee structure and payment options. This policy shall include written acknowledgement of understanding from the individual. The individual will be provided with a copy of this document and a copy will be placed in the clinical record.
  3. Conditions for dosing, counseling and toxicology sample collection. The policy shall include provisions for holding doses, evaluation of the “impaired” individual, treatment stipulations and agreements, “refusal” or “inability” to provide specimens for toxicology testing and unacceptable/unsafe behavior that limits the individual’s ability to participate in OMAT.
  4. Take-home dose privilege phase system.
  5. Special privilege exception requests.
  6. Consequences for violating policies; and,
  7. Written procedures and signed individual acknowledgements around the following shall include, but not limited to:
    - a. Behavioral agreements;
    - b. Office treatment lock-in;
    - c. Office treatment lock-out;
    - d. Reductions in take-home dose privileges;
    - e. Administrative discharges;
    - f. Administrative transfers;
    - g. Courtesy dosing;
    - h. OMAT transfer policy;
    - i. Taper protocol for any and all circumstances including inability to pay;
    - j. Hospitalization while in OMAT instructions including, clinic after hours information;
    - k. Emergency procedures in case of a natural disaster or emergent closing of the clinic;
    - l. Use of Prescription Drug Monitoring Program in treatment;
    - m. Use of other prescription medications in treatment; and,
    - n. Provisions around conditions for dosing.

**21.320.42 Other Prescription Medications [Eff. 11/1/13]**

- A. Individuals will bring in all personal prescription medications for review to the program.
- B. The program shall assess and document the appropriateness of use of personal medications.
- C. Programs will have a policy for the assessment of all prescription medication that an individual may bring in.

**21.320.5 PRESCRIBING, DISPENSING, AND ADMINISTERING APPROVED CONTROLLED SUBSTANCES [Eff. 11/1/13]**

- A. OMAT medical directors or other OMAT physicians shall order approved controlled substances and document orders in individual records.
- B. Standing dosing orders shall be approved by OMAT medical directors and the Department.
- C. OMAT physicians, nurse practitioners, or physician assistants shall administer approved controlled substances.
- D. Exceptions to dosing regimens outlined in federal regulations shall require approval by the Department prior to dosing.
- E. Approved controlled substances shall be administered by OMATs according to manufacturer's specifications found on product labels and/or in printed instructions accompanying the product.
- F. In circumstances where individuals must be administratively withdrawn from methadone due to inability or unwillingness to pay treatment fees, OMATs shall provide a safe medical taper if necessary. Pregnant women shall have the option to defer payment for treatment and continue to receive OMAT.

**21.320.6 EVALUATIONS AND ASSESSMENTS**

**21.320.61 General Provisions [Eff. 11/1/13]**

- A. Individuals re-admitted to treatment following treatment absences of six (6) months or more shall undergo medical evaluations, physical examinations, and/or laboratory tests as deemed appropriate by OMAT medical directors or other healthcare providers.
- B. Other medical concerns shall be addressed by OMATs or referred to other medical agencies when appropriate as determined by OMAT medical directors or other health care providers

**21.320.62 Medical Evaluations [Eff. 11/1/13]**

Individuals admitted to OMATs shall have medical evaluations conducted by medical directors, other OMAT physicians, nurse practitioners, or physician assistants prior to the first dose. Medical evaluations shall include, at minimum, the following:

- A. Past medical history, past substance abuse history including required opioid use and dependence chronologies, choice of opioid and route of administration;
- B. Evidence of current physiological dependence; and
- C. Cardiovascular assessment for the risk of Torsades de Pointe.

**21.320.63 Physical Examinations [Eff. 11/1/13]**

- A. Thorough physical examinations shall be conducted, evaluated and documented in individual records by medical directors or other OMAT physicians within fourteen (14) consecutive calendar days following treatment admission and every two (2) consecutive years from date of admission.
- B. At a minimum, physical examinations shall consist of:
  - 1. Examinations of organ systems for possible infectious diseases and pulmonary, liver, and cardiac abnormalities;
  - 2. Checks for dermatologic indication of addiction;
  - 3. Vital signs (temperature, pulse, blood pressure and respiratory rate);
  - 4. Evaluations of individuals' general appearance;
  - 5. Inspections of head, ears, eyes, nose, throat (thyroid), chest (including heart and lungs), abdomen, extremities, and skin (tracks, scarring, abscesses);
  - 6. Neurological assessments; altered mental status.

**21.320.64 Laboratory Tests [Eff. 11/1/13]**

- A. Admission laboratory tests shall be conducted with individual consent either on-site or through referral, and results shall be evaluated and documented in individual records within fourteen (14) consecutive calendar days following treatment. Admission laboratory tests shall include:
  - 1. Serological test for syphilis;
  - 2. Tuberculin skin test and/or other tests for tuberculosis when clinically indicated;
  - 3. Urine toxicology or other tests to determine current drug use;
  - 4. Complete blood count and differential, as clinically indicated;
  - 5. Routine and microscopic urinalysis, as clinically indicated;
  - 6. Liver function tests;
  - 7. Test for Hepatitis B, C, and Delta when clinically indicated;
  - 8. Test for HIV/AIDS when clinically indicated.
- B. The following laboratory tests shall be conducted with consent, every two (2) consecutive years from date of admission.
  - 1. Tuberculin skin test and/or other tests for tuberculosis when clinically indicated.
  - 2. Complete blood count and differential, as clinically indicated.
  - 3. Liver function profile, as clinically indicated.

**21.320.7 TOXICOLOGY SCREENS/URINE DRUG SCREENS [Eff. 11/1/13]**

- A. OMATs shall develop and implement policies and procedures that ensure a random sample collection protocol that minimizes falsification and limits individual's inability or refusal to provide specimens for testing.
  - 1. Individuals shall have no notification prior to the day they are required to give a sample.
  - 2. Individuals shall not be allowed to give a sample on days they normally attend the clinic unless those days are coincidentally randomly assigned sample days.
- B. OMATs shall develop and implement policies and procedures that establish treatment responses to the following:
  - 1. Evidence of unauthorized drugs in toxicology screens, including prescription medications;
  - 2. Lack of OMAT-administered controlled substances in toxicology screens, including Suboxone;
  - 3. Dilute urine analysis;
  - 4. Use of the prescription drug monitoring program.
- C. Procedures for toxicology screens shall be designed and implemented to ensure random sample collection in accordance with requirements for each phase of take-home dose privileges.
- D. Toxicology screens shall occur with the following frequencies:
  - 1. One (1) toxicology screen at admission;
  - 2. Minimum of one (1) monthly random toxicology screen;
  - 3. An initial toxicology screen for individuals undergoing short-term detoxification;
  - 4. An initial toxicology screen and at least one (1) random toxicology screen per month for individuals undergoing long-term detoxification;
  - 5. At least one random toxicology screen during thirty day reductions in take-home dose privileges.
- E. Refusal to provide samples for toxicology screens shall be considered to be positive toxicology screens.
- F. Dilute urinalysis will be reviewed and assessed.
- G. Toxicology screens shall be used to detect the presence of the following drugs:
  - 1. All approved controlled substances and their metabolites, for which laboratory analyses are available;
  - 2. Alcohol;
  - 3. Morphine;
  - 4. Other opioids;

5. Cocaine and its metabolite;
6. Amphetamines;
7. Benzodiazepines;
8. Marijuana (THC);
9. Other drugs when clinically indicated, if available including, but not limited to, club drugs, and any over-the-counter drugs an individual might be abusing.

**21.320.8 TAKE-HOME DOSE PRIVILEGES**

**21.320.81 Take-Home Dose Protocols [Eff. 11/1/13]**

- A. Individuals may qualify to self-administer methadone doses at locations other than OMATs if they meet all the criteria for each of six (6) phases of take-home dose privileges. Individuals shall qualify for each phase sequentially and must have the following, at minimum, in addition to length of time for each phase:
1. Most recent toxicology screen is negative;
  2. Clinical assessments completed;
  3. Minimum of one (1) hour of counseling per month;
  4. No unexcused dosing absences;
  5. No unexcused counseling absences;
  6. Compliance with OMAT policies and procedures;
  7. No known recent criminal activity;
  8. No alcohol abuse;
  9. Competent to safely handle take-home doses;
  10. Responsible behavior;
  11. Stable living environments;
  12. Stable social relationships;
  13. Adherence to service plans; and,
  14. Compliance with on-site dosing schedules.
    - a. In addition to items 1-14, above, Phase 1 permits a take-home dose for Sunday and one (1) additional take-home dose per week on or after the first ninety (90) consecutive calendar days of treatment.

- b. In addition to items 1-14, Phase 2 permits a take-home dose for Sunday and two (2) additional take-home doses per week when the individual has completed four or more consecutive months in treatment, and the most recent two consecutive urine screens are negative. Individuals shall receive no more than two (2) consecutive calendar days of take-home doses.
- c. In addition to items 1-14, Phase 3 permits a take-home dose for Sunday and three (3) additional take-home doses per week when the individual has completed six or more consecutive months in treatment, and the most recent three consecutive urine drug screens are negative. Individuals shall receive no more than two (2) consecutive days of take-home doses.
- d. Individuals may qualify for Phase 4 when, in addition to items 1-14, an individual has completed nine or more months in treatment and the most recent four (4) consecutive toxicology screens are negative. Phase 4 permits a take-home dose for Sunday and five (5) additional take-home doses per week.
- e. Phase 5 permits thirteen (13) take-home doses per two-week period. Individuals may qualify for Phase 5 when, in addition to items 1-14, the individual has completed one or more years in treatment, most recent six (6) consecutive toxicology screens are negative, and the phase has been approved by the State of Colorado.
- f. Phase 6 permits twenty-eight (28) to thirty (30) take-home doses per month. Individuals may qualify for Phase 6 when, in addition to the above, the following criteria are met:
  - 1) Completed two (2) or more years in treatment;
  - 2) Most recent twelve (12) consecutive toxicology screens are negative;
  - 3) Individual/clinic applications for Phase 6 take-home dose privileges have been reviewed and approved by the Department in consult with the take-home dose privilege board.
- B. Individuals transferring from out of state must meet the Colorado state requirements for the take out phase they are requesting.
- C. All phases must receive special state approval for take-outs beyond their approved week schedule.
- D. Individual/clinic applications for Phase 6 take-home dose privileges shall be submitted to and approved by a privilege board comprised of the Department controlled substance administrator or that individual's designee and OMAT directors or their designees.
- E. Take-home doses may be approved by OMATs for days clinics are closed, including Sundays and state and federal holidays.
- F. Take-home doses shall not be approved for individuals undergoing short-term detoxification.
- G. Written agreements shall be developed and implemented for individuals approved for take-home doses. Agreements shall be part of the service plan and shall explain the rationale for approving take-home dose privilege phases, stipulate dose amounts and set consequences for violating agreement conditions.

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- H. Take-home doses shall be dispensed in medication containers that conform to state and federal poison prevention packaging requirements, including childproof lids.
- I. Labels shall be affixed to containers with the following information:
1. OMAT names, addresses, and telephone numbers;
  2. Individual names;
  3. Drug types;
  4. Dose amounts, if not physician-authorized blind doses;
  5. Directions for use.
- J. Take-home doses numbering twelve (12) or less shall be transported in a discrete and secure manner agreed upon by OMATs and individuals.
- K. Take-home doses numbering thirteen (13) or more shall be transported in locked containers constructed of rigid materials that resist tampering.
- L. Take-home doses shall be securely and discretely stored where individuals' reside, in a manner that reduces the risk for access by children and unauthorized individuals.
- M. OMAT programs shall submit and obtain Department approval for the following:
1. Split doses with the exception of pregnant women;
  2. Take-home doses for individual detoxification lasting less than thirty (30) consecutive calendar days;
  3. Take-home doses that do not conform to take-home dose phase requirements;
  4. Take-home medication doses for individuals with unacceptable urine drug screen results within the last ninety (90) calendar days;
  5. Take-home doses for OMAT individuals admitted to extended health care agencies or a licensed residential substance use disorder agencies;
  6. Phase 5 take-home doses.
- N. Requests for thirty one (31) take-home doses or more for individuals in Phase 6 shall require the federal Center for Substance Abuse Treatment (CSAT) approval in addition to Department approval.
- O. Individuals reporting loss or theft of take-home doses shall not be provided replacement doses or daily doses, until the day after the last take-home dose would have been taken, or unless they are pregnant.
- P. OMATs shall have policies and procedures for transporting methadone or other approved controlled substances to individuals in residential treatment or recovery agencies that includes a secure plan for storage from the facility.

**21.320.82 Reductions in Take-Home Dose Privilege Phases [Eff. 11/1/13]**

- A. Illicit positive toxicology screens and unexcused dosing and counseling absences shall result in thirty-day reductions in take-home dose privilege phases.
- B. Positive toxicology screens during thirty-day reduction periods shall result in further reductions in privilege phases.
- C. Privilege phases for which individuals qualified prior to reductions may be sequentially restored at a rate of one (1) phase every thirty (30) consecutive calendar days if toxicology screens remain negative and all other requirements are met.

**21.320.9 COOPERATION, THEFT/DIVERSION AND CENTRAL REGISTRY [Eff. 11/1/13]**

- A. OMAT programs shall develop with the Office and adhere to all Department regulations pertinent to OMAT.
- B. OMATs shall cooperate with the Department in developing, implementing, updating, and adhering to, the Memorandum of Cooperation and all policies and procedures pertinent to the regulation of OMAT.
- C. OMAT programs shall follow all policies and procedures related to controlled substances licensing.
- D. OMATs shall prevent simultaneous enrollment of individuals in more than one clinic by fully participating in the Department Central Registry of opioid individuals.
  - 1. Prior to admitting applicants to treatment, OMATs shall initiate a clearance inquiry to the Department's Central Registry of opioid individuals by submitting applicant information in Department prescribed formats.
  - 2. Applicant information shall include:
    - a. Name;
    - b. Date of birth;
    - c. Social security number;
    - d. Proposed date of admission; and
    - e. Other information required by the individual clearance procedure.
  - 3. Applicants shall not be admitted to treatment when the Department's Central Registry shows them as currently enrolled in another OMAT.
  - 4. It is the responsibility of the Department's Central Registry.
  - 5. In the event that the Central Registry is down or the Department is closed, clinics may call each other to verify whether or not one is open at another clinic. If one is not able to verify then the individual may have to wait until this can be verified.
  - 6. OMATs shall report clinic admissions and discharges to the Department's Central Registry within three (3) business days.

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**21.330 ADDICTION COUNSELOR CERTIFICATION AND LICENSURE**

**21.330.1 DEFINITIONS [Eff. 5/1/16]**

“Accredited Institution of Higher Education” means an institution of higher learning that is accredited by one of the following: the Commission on Institutions of Higher Education of the New England Association of Colleges and Schools; Higher Learning Commission (formerly known as the Commission on Institutions of Higher Education) of the North Central Association of Colleges and Schools; the Commission on Higher Education of the Middle States Association of Colleges and Schools; the Accrediting Commission for Senior Colleges and Universities of the Western Association Schools and Colleges; the Accrediting Commission for Community and Junior Colleges of the Western Association of Schools and Colleges; the Commission on Colleges of the Northwest Association of Schools and Colleges; the Commission on Colleges of the Southern Association of Colleges and Schools; or as determined and approved by the Department.

“Addiction” means a persistent, compulsive dependence on a substance that may also include mood-altering behaviors or activities called process addictions.

“Administrative Supervision” means oversight of agency operations, organization of people and resources, and implementation of policies and procedures in a way that directs activities towards agency goals and objectives.

“Administrative Supervisor” means responsibility for the non-clinical functioning of an employee, intern, volunteer or counselor-in-training.

“Behavioral Health Disorder” means, for the purposes of these rules, both a mental health and/or a substance use disorder.

“Behavioral Health Sciences” means, for the purposes of these rules, any concentration that focuses on health behavior that is impacted by psychological, behavioral, social and cultural factors, and that applies knowledge and tools in behavioral theory, research, assessment, program planning, and counseling.

“CAC” for the purposes of these rules is a Certified Addiction Counselor.

“Clinical Consultation” means a voluntary relationship between professionals of relative equal expertise or status wherein the consultant offers their best advice or information on an individual case or problem for use by the consultee as deemed appropriate based on professional judgment.

“Clinical Degree” means:

- A. Master's degree or Doctoral degree with any of the following designations in the behavioral health sciences: agency counseling, community counseling, guidance and counseling, human services counseling, marriage and family therapy, rehabilitation counseling, psychology, counseling psychology, human psychology, educational psychology, clinical social work, psychiatric nursing, and behavioral health sciences; or,
- B. Master's or Doctoral degree as determined by the Department to be equivalent to an accredited program with a clinical emphasis.

“Clinical Supervisor” means a qualified person who is responsible for monitoring the professional development and clinical actions of his/her supervisees. The clinical supervisor provides leadership, models professionalism, promotes development of clinical skills and competencies, provides ongoing evaluation of counselor skill level, promotes accountability, assures adequate training, and monitors individual welfare and safety. The clinical supervisor may be held accountable for misconduct by a supervisee when the supervisor knew or should have known of a violation of generally accepted standards of practice or any prohibited activity by the supervisee.

“Clinical Supervision” means the supervisee's clinical practice is evaluated and either modified or approved by the supervisor. Clinical supervision provides a source of knowledge, expertise, and more advanced skills to the person being supervised. Provision of supervision is preferred on site, but may occur on or off the site of service.

“Clinically Supervised Work Experience” means paid or unpaid addiction specific treatment activities that are supervised by a qualified person. It includes those hours that are accumulated as a counselor-in-training, employee, volunteer, student, intern or equivalent status.

“Conflict of Interest” means, for the purposes of these rules, that a conflict exists between the private interests and the official or professional responsibilities of a person in a position of trust such that the person has competing professional or personal interests that may influence the person's ability to perform job duties and fulfill job responsibilities such that an independent observer might reasonably question whether the person's professional actions or decisions are improperly influenced by personal considerations.

“Counseling” means the application of special knowledge, skills, and abilities in performing the counseling core functions utilized in support of the service plan and exercised under clinical supervision to assist persons, families or groups in achieving objectives through exploration of attitudes and feelings, consideration of alternative solutions and making decisions that support a process of recovery.

“DORA” means the Department of Regulatory Agencies.

“LAC” means a Licensed Addiction Counselor.

“Linkage” means aiding a person to access needed services.

“Maintenance Treatment” means treatment that follows the completion of primary treatment. As used in the stages of change model, maintenance treatment is the level of care that assists the person in maintaining behavioral changes over time.

“Primary Treatment” means a treatment episode or process that occurs as a result of voluntary or mandated admission to treatment with the goal of stabilization and motivation toward abstinence from the problematic behavior.

“Process Addiction” means addiction to a mood-altering activity or process. These mood altering activities or behaviors may include, but are not limited to, gambling, eating, and sexual activity.

“Proration of Supervision Hours” means those clinical supervision hours that may be prorated according to the current credentialing level of the counselor-in-training based on number of hours worked, but no less than one hour per month.

“Recovery” means a personal process through which an individual is able to change attitudes, emotions, and behaviors in relation to a problematic behavior. Recovery focuses on easing the acute symptoms of withdrawal, stabilization, the development of coping mechanisms to avoid further problematic behavior patterns, and practicing alternative, healthy behaviors that lead to long-term maintenance of recovery.

“Recovery Management” means a time-sustained, recovery-focused collaboration between service consumers and service providers toward the goal of stabilizing, and then actively managing behavioral health disorders until full remission has been achieved or until recovery maintenance can be self-managed by the person.

“Screening” means the first phase of evaluation to determine if the person is appropriate for a specific treatment facility and/or treatment 3m and to determine the possible presence or absence of a substance use disorder or mental health disorder.

“Substance Use Disorder” means a complex behavioral disorder of continual psychoactive substance use characterized by preoccupation with using alcohol or other drugs, increased consumption and loss of control.

“Vicarious Liability” means the legal principle that holds one person liable for the actions of another when engaged in some form of joint or collective activity or when he/she has a particular legal relationship to the person who acted negligently.

“Work Verification Form” (WVF) means the form that is used to document clinically supervised work experience hours.

**21.330.2 ADDICTION COUNSELING COMPETENCIES [Eff. 5/1/16]**

Addiction counseling competencies consist of the following:

- A. Professional addiction counseling consists of the application of general counseling theories and treatment methods adapted specifically for working with addictive disorders. Addiction counseling focuses on four sets of competencies:
  - 1. Understanding addiction;
  - 2. Treatment knowledge;
  - 3. Application to practice;
  - 4. Professional readiness.
  
- B. The ten primary practice dimensions or critical work functions of addiction counseling are:
  - 1. Clinical Evaluation
    - a. Screening;
    - b. Assessment.
  - 2. Clinical Intake, Discharge Planning, and Discharge.
  - 3. Service Planning
    - a. Creation of initial service plan;
    - b. Implementation of service plan;
    - c. Service plan review and update.

4. Service Coordination
  - a. Ongoing evaluation, assessment, and treatment;
  - b. Consultation with other professionals;
  - c. Referral;
  - d. Advocacy on behalf of the individual;
  - e. Continuing service planning.
5. Addiction Counseling
  - a. Individual, groups, families, couples, significant others;
  - b. Crisis intervention;
  - c. Culturally specific treatment;
  - d. Recovery management.
6. Case management.
7. Individual, family, and community education concerning addiction.
8. Documentation required for the clinical record.
9. Professional and Ethical Responsibilities
  - a. Code of ethics;
  - b. Knowledge of the laws and rules that relate to the practice of psychotherapy and addiction counseling;
  - c. Ongoing professional development;
  - d. Ethical therapeutic and business practices.
10. Clinical Supervision

Exercise supervisory responsibility for the clinical work performed by the supervisee, to include skill development, performance evaluations and professional responsibility.

**21.330.3 LEVELS OF CERTIFICATION AND LICENSURE [Eff. 11/1/13]**

Addiction counselors may be certified at one of three levels (CAC I, CAC II, or CAC III) or licensed (LAC) and be identified as one of the following:

- A. Certified Addiction Counselor Level I, hereinafter referred to in these rules as a CAC I, is defined as an entry-level certification. Individuals with this certification shall not conduct individual or group counseling services independently. A CAC I may co-facilitate individual or group counseling services or assume other therapeutic co-facilitation duties with supervisory oversight from a CAC II, CAC III, or LAC present in the room. A CAC I may write treatment progress notes, conduct Level I education groups and Minor in Possession (MIP) groups when cosigned by a CAC II, CAC III, or LAC.
- B. Certified Addictions Counselor Level II, hereinafter referred to in these rules as a CAC II, is defined as a counselor who may conduct addiction treatment services independently for individuals, families, and groups. A CAC II may perform the complete range of duties associated with addiction treatment, with the exception of clinical supervision. Passing a national examination as determined and approved by the Department shall be required for certification as a CAC II.
- C. Certified Addictions Counselor Level III, hereinafter referred to in these rules as a CAC III, has the authority to practice independently and assume clinical supervision duties shall have successfully completed the required clinical supervision training. Documentation of a Bachelor's degree or above in the behavioral health sciences is required at the CAC III level. Passing of a national examination as determined and approved by the Department shall be required for certification as a CAC III.
- D. Licensed Addiction Counselor, hereinafter referred to in these rules as a LAC, has the authority to practice independently and assume clinical supervision duties. All requirements for the CAC III shall be met including clinical supervision. Documentation of a Master's or Doctoral degree in the behavioral health sciences or an equivalent program from a regionally accredited institution of higher education and passing a national examination as determined and approved by the Department. A LAC may also supervise other licensed and unlicensed mental health professionals with the approval of the appropriate board regulated by the Department of Regulatory Agencies.

**21.330.4 CERTIFICATION BY CLINICALLY SUPERVISED WORK EXPERIENCE, EDUCATION, TRAINING, AND EXAMINATION [Eff. 11/1/13]**

All applicants shall demonstrate proficiency in addiction counseling skills and competencies as referenced in Section 21.330.2. This shall be accomplished by successfully completing an academic degree and Department approved training and examinations. Courses in the behavioral health sciences obtained from accredited institutions of higher education may be equivalent to the Department required training.

**21.330.41 Clinically Supervised Work Experience [Eff. 11/1/13]**

"Clinically supervised work experience" is defined as paid or unpaid addiction specific counseling. Addiction counseling work experience does not have to be acquired in a substance use disorder treatment program licensed by the Department; however it shall meet the criteria as stated in Sections 21.330.5, 21.330.6 and 21.330.7.

- A. Clinical supervision of work experience hours shall be provided by a CAC III or LAC in accordance with Section 21.300.7. Supervision for a CAC II or CAC III may also be provided by a qualified individual with education, training, and work experience in addiction counseling as determined by the Department.

- B. Counselors-in-training who are accumulating the first one thousand (1,000) clinically supervised work experience hours towards a CAC I shall be observed while providing addiction counseling a minimum of one time per month by their clinical supervisor of record and shall be documented by the supervisor.
- C. A counselor-in-training or the holder of a CAC I who is accumulating two thousand (2,000) clinically supervised work experience hours towards a CAC II shall be observed a minimum of one time every three months by their clinical supervisor of record and shall be documented by the supervisor.
- D. Clinically supervised work experience hours may only be accumulated when an individual is working in the addiction treatment field and is at least eighteen (18) years of age.
- E. Individuals may accumulate clinically supervised work experience hours while receiving maintenance treatment for a substance use disorder or process addiction provided all other requirements of these rules are met.
- F. Individuals may not accumulate clinically supervised work experience hours while at the same time receiving primary treatment for substance use disorders or process addictions as this is considered to be a conflict of interest.
- G. Clinically supervised work experience hours may be accumulated while an individual is on probation or parole provided all other requirements of these rules are met. However, no applications for a CAC I, CAC II, CAC III or LAC shall be submitted to DORA while the applicant is on probation or parole as this is considered to be a conflict of interest.
- H. The Work Verification Form (WVF) shall be used to document clinically supervised work experience hours. The WVF is part of the application and shall be completed by the applicant and the clinical supervisor for all work experience credit. The WVF shall document information ensuring that the applicant meets the necessary requirements of this rule. The applicant shall submit a job description if requested by DORA. The clinical supervisor shall submit clinical supervision records if requested by DORA.
- I. If the clinically supervised work experience occurred outside of the State of Colorado or outside of a licensed substance use disorder treatment program in Colorado, the work experience shall meet all requirements in Sections 21.330.5, 21.330.6 and 21.330.7. Clinical supervision shall have been provided according to supervision requirements equivalent to those of the State of Colorado.

**21.330.42 Training [Eff. 11/1/13]**

- A. Education requirements shall be met as referenced in Sections 21.330.5 and 21.330.6.
- B. Department approved college courses and training classes shall be delivered by a Department approved trainer or instructor. Training classes shall be at least seven (7) clock hours in length.
- C. Required training classes shall include an examination and shall be verified by a certificate of completion as determined and approved by the Department.
- D. Required training classes shall be completed within five (5) years prior to the application received date by the Department of Regulatory Agencies.
- E. Academic degrees obtained in the behavioral health sciences as determined and approved by the Department shall have no expiration date.

- F. Courses in the behavioral health sciences obtained from accredited institutions of higher education equivalent to the Department required training shall be demonstrated through official transcripts and syllabi and/or course descriptions. In addition, upon proof satisfactory to the Department, other accrediting bodies may be approved on a case-by-case basis. A grade of C or above shall be required on the transcript to receive training credit toward counselor certification. Course credit hours shall be calculated as follows: fifteen (15) clock hours for each semester hour and eight and one-half (8.5) clock hours for each quarter hour.
- G. Passage of a national examination as determined and approved by the Department shall be required for certification as a CAC II or CAC III and for licensure as a LAC.

**21.330.5 CERTIFICATION REQUIREMENTS**

**21.330.51 Certified Addiction Counselor I (CAC I) [Eff. 11/1/13]**

All of the following requirements must be met prior to application for certification as a CAC I:

- A. Be at least eighteen (18) years of age.
- B. Documentation and/or proof of high school diploma or its equivalent.
- C. Documentation of all required training for a CAC I shall be completed within five (5) years prior to the application received date by the Department of Regulatory Agencies.
- D. Documentation of one thousand (1,000) hours of clinically supervised work experience completed in a minimum of six (6) months and shall consist of at least three (3) of the following individual care functions:
  - 1. Orientation;
  - 2. Administrative intake;
  - 3. Administrative discharge and discharge planning;
  - 4. Service coordination;
  - 5. Record keeping;
  - 6. Individual, family, and community education;
  - 7. Co-facilitation of individual, family or group counseling with a CAC II, CAC III, or LAC present.
- E. Documentation of clinical supervision at a minimum of three (3) hours per month by a CAC III or LAC for full-time work experience credit being sought, or pro-rated for part time work experience but no less than one (1) hour per month.

**21.330.52 Certified Addiction Counselor II (CAC II) [Eff. 11/1/13]**

All of the following requirements must be met prior to application for certification as a CAC II:

- A. Be at least eighteen (18) years of age.
- B. Documentation and/or proof of a high school diploma or its equivalent.

- C. Documented completion of all CAC I requirements or copy of CAC I certification already awarded.
- D. Documentation of all Department required training for a CAC II shall be completed within five (5) years prior to the application received date by DORA.
- E. Documentation of two thousand (2,000) additional hours of clinically supervised work experience beyond the CAC I requirement, completed in twelve (12) months consisting of at least six (6) of the following addiction treatment functions:
  - 1. Clinical evaluation to include screening and assessment;
  - 2. Clinical intake, discharge planning, and discharge;
  - 3. Service planning;
  - 4. Care coordination, including linkage and referral;
  - 5. Case management;
  - 6. Individual, family, and community education;
  - 7. Documentation required for a clinical record.
- F. Documentation of clinical supervision of a minimum of three (3) hours per month by a CAC III or LAC for full time work experience credit or pro-rated for part-time work experience but no less than one (1) hour per month.
- G. Documentation of passage of a national examination as determined by the Department. Completion of a national examination for the purposes of these rules does not constitute national certification.
- H. For individuals who hold a clinical master's or clinical doctoral degree, documentation shall be provided showing successful completion of certain required training classes or their equivalent as determined and approved by the Department. All Department required classes must be completed within five (5) years prior to the application received date by DORA. Requirements for work experience hours, clinical supervision and college/education class equivalency shall be determined by the Department.

**21.330.53 Certified Addiction Counselor III (CAC III) [Eff. 11/1/13]**

All of the following requirements must be met prior to application for certification as a CAC III:

- A. Be at least eighteen (18) years of age.
- B. Documentation of a Bachelor's degree or above in the behavioral health sciences. .
- C. Documentation of an active CAC II certification already awarded. For those holding a clinical master's or clinical doctoral degree as determined and approved by the Department, this requirement shall be waived.
- D. Documentation of required training as determined and approved by the Department that must be completed within five (5) years prior to the application received date by DORA.

- E. Documentation of two thousand (2,000) additional hours beyond the CAC II requirements of clinically supervised work experience hours completed in a minimum of twelve (12) months consisting of the following addiction treatment functions:
  - 1. Clinical evaluation to include screening and assessment;
  - 2. Clinical intake, discharge planning, and discharge;
  - 3. Service planning;
  - 4. Care coordination, including linkage and referral;
  - 5. Individual and/or family and/or group counseling;
  - 6. Case management;
  - 7. Individual, family, and community education;
  - 8. Documentation required for a clinical record.
- F. Documentation of clinical supervision of a minimum of two (2) hours per month by a CAC III or LAC for full time work experience credit or prorated for part time work experience, but no less than one (1) hour per month. A clinical supervisor other than a CAC III or LAC must meet requirements as determined and approved by the Department.
- G. Documentation of successfully passing a national examination as determined and approved by the Department. Completion of a national examination for the purposes of these rules does not constitute national certification.
- H. For individuals who hold a clinical master's or clinical doctoral degree, documentation shall be provided showing successful completion of certain required training classes or their equivalent. All such classes shall be completed within five (5) years prior to the application receipt date by DORA. Requirements for work experience hours and clinical supervision shall be determined by the Department.
- I. Those individuals who currently hold a CAC III shall engage in one hour per month of documented clinical consultation with a CAC III, LAC or other qualified clinical professional that may be obtained face-to-face or by the use of telephone or other electronic means.

**21.330.6 REQUIREMENTS FOR LICENSED ADDICTION COUNSELORS (LAC) [Eff. 11/1/13]**

An individual applying for licensure as an addiction counselor must meet the following requirements:

- A. Be at least twenty-one (21) years of age.
- B. Hold an active, valid certificate in good standing of a CAC III or meet all requirements of a CAC III;
- C. Possess a Master's or Doctoral degree in the behavioral health sciences or an equivalent program from a regionally accredited institution of higher education. The applicant who has been trained in addiction counseling or earned a clinical degree outside the United States has the responsibility of presenting evidence to DORA to prove equivalency to an advanced degree awarded in the United States from a regionally accredited institution of higher education; and,

- D. Pass a national examination as determined and approved by the Department. The examination must have been taken after the Master's degree used for licensure has been conferred. Completion of a national examination for the purposes of these rules does not constitute national certification.

**21.330.7 REQUIREMENTS FOR CLINICAL SUPERVISION PROVIDED BY A CAC III AND LAC**  
**[Eff. 11/1/13]**

Those individuals holding an active CAC III or LAC are designated providers of clinical supervision in the addiction counseling field. Clinical supervision shall be delivered in either a group or individually. Group clinical supervision is limited to no more than six supervisees.

Qualifications, competencies, and duties in Subsections 21.330.71 through 21.330.73 are required for the clinical supervisor designation. A description of dual relationships that are to be avoided by the clinical supervisor is included in Subsection 21.330.74.

**21.330.71 Qualifications of the Clinical Supervisor [Eff. 11/1/13]**

- A. The supervisor shall have clinical experience and competence adequate to perform and direct the services provided by the supervisee including knowledge of legal, ethical, and professional standards.
- B. The clinical supervisor shall be able to identify the learning needs of the supervisee and use methods that are appropriate to the supervisee's level of development, training, and experience.
- C. The supervisor shall hold an active CAC III or LAC in good standing. A clinical supervisor other than a CAC III or LAC must meet all training and work experience requirements as determined and approved by the Department.

**21.330.72 Core Competencies of the Clinical Supervisor [Eff. 11/1/13]**

- A. Clinical supervisors shall assist supervisees to develop knowledge and skills in providing individual care, treatment collaboration, continued learning, and professional readiness.
- B. Clinical supervisors shall exercise supervisory responsibility for the clinical work performed by their supervisees including, but not limited to, counselor skill development and assessment, counselor performance evaluations, and professional responsibility.
- C. Clinical supervisors shall be responsible for the professional activities of their designated supervisees. They shall communicate to a supervisee an understanding of legal and regulatory requirements and their impact on the profession including, but not limited to, certification, licensure, duty to warn of danger to self or others, confidentiality, and rights of individuals receiving treatment. They shall communicate to the supervisee an understanding of ethical considerations that pertain to the supervisory process including, but not limited to, dual relationships, due process, informed consent and vicarious liability.
- D. Clinical supervisors shall be available for emergency consultation with supervisees.
- E. Clinical supervisors shall be able to interrupt or stop the supervisee from practicing counseling for cause and to terminate the supervisory relationship as indicated.
- F. Clinical supervisors shall document the dates supervision sessions occurred, length of the session, description of the supervision topics and any recommendations made, the name of the supervisor and credentials, and the names of supervisees. Clinical supervisors shall assure that supervisees receive copies of supervisory records.

- G. Clinical supervisors shall document and maintain the following as part of the supervisory record:
1. Supervisor evaluation of supervisee work performance at least once every six months.
  2. Supervisee evaluation of supervision received at least once every six months.
  3. Clinically supervised work experience hours shall be documented on Work Verification Forms (WVF) or the equivalent.
  4. Termination of supervision with reasons for such termination.

**21.330.73 Duties of the Clinical Supervisor [Eff. 11/1/13]**

Supervision shall include, but is not limited to, the following activities:

- A. Documented observation of the supervisee's clinical practice by the supervisor that may include, but not be limited to, audio, video, two-way mirror, co-facilitation and/or direct observation.
- B. Monitoring of the supervisee's clinical practice to verify that the services being provided to individuals meet generally accepted standards of practice for addiction counselors.
- C. Review of individual charts maintained by the supervisee for accuracy, completeness, and timeliness.
- D. Verification of provision of mandatory disclosure form by the supervisee pursuant to Section 12-43-214, C.R.S.
- E. Verification that individuals are informed as to any changes in the supervisory relationship.
- F. Keeping and maintaining records documenting supervision that meets the generally accepted standards of practice pursuant to Section 12-43-222(1)(n), C.R.S.

**21.330.74 Dual Relationships in Clinical Supervision [Eff. 11/1/13]**

- A. Dual relationships in clinical supervision to be avoided include, but are not limited to, the following:
1. Blood relatives.
  2. Spousal relationships or significant others, either current or former.
  3. Students, interns, therapists, or individuals who have received treatment from the clinical supervisor either current or former.
  4. Any other relationship that might compromise therapist/individual who has received treatment from the therapist, supervisor/supervisee or, supervisor/individual who has received treatment from the supervisor relationship.
- B. DORA may grant an exception to item A above upon showing that:
1. The dual relationships listed in Section 21.330.74, A, were fully informed of the dual relationship and the possibilities for conflicts of interest;
  2. The person involved in the supervisory relationship's access to quality care has not been compromised;

3. The supervisor and the supervisee have not benefited from the relationship over and above reasonable fee for service (i.e., that the power in the relationship has not been used to influence the relationship for personal gain);
4. The supervisory relationship has not been compromised and the best interests of the supervisee are served by the relationship.

**21.330.8 APPLICATIONS**

**21.330.81 Application for Initial Certification for CAC I, II, III, or LAC [Eff. 11/1/13]**

An application for initial certification shall include a completed DORA application, applicable fee, DORA developed jurisprudence examination, and official documentation of passing a national exam as applicable.

**21.330.82 Application for Reinstatement of Certification or Licensure [Eff. 11/1/13]**

An applicant whose certification or license has expired for more than two (2) years shall complete the DORA reinstatement application; pass a DORA developed jurisprudence examination, and demonstrate continued professional competence by documenting one of the following:

- A. Completion of required training as determined and approved by the Department which must be taken and passed within the past two (2) years prior to the application received date by DORA.
- B. A national examination as determined and approved by the Department taken and passed within the past two (2) years prior to the application received date by DORA.

**21.330.83 Application for Endorsement [Eff. 11/1/13]**

These rules establish criteria for consideration of certification or licensure by endorsement. An applicant has the responsibility for establishing that their credentials, work experience, and qualifications are substantially equivalent to the level of endorsement being sought.

- A. Complete the DORA endorsement application, pass a DORA developed jurisprudence examination, and provide documentation of holding, in good standing, a current, active and verifiable international, national or state certification or license or its equivalent as determined by the Department.
- B. The applicant shall submit documentation to DORA demonstrating that the addiction counseling clinical training, clinically supervised work experience hours, and clinical supervision received for their existing certification, license or similar credential is substantially equivalent to that required for the CAC I, CAC II, CAC III or LAC as defined in Sections 21.330.5 and 21.330.6. DORA may request additional information from the applicant as needed.
- C. DORA may decline to issue a certificate or license by endorsement to an applicant against whom disciplinary action has been taken or is pending related to his/her practice, about whom an investigation is being conducted in connection with his/her practice, or who is the subject of an unresolved complaint related to his/her practice.

**21.330.9 INFORMATION REQUIRED TO BE REPORTED TO DORA**

**21.330.91 Reporting Violations [Eff. 11/1/13]**

- A. Addiction counselors are required to report violations of Section 12-43-222, C.R.S. to DORA once they have direct knowledge that a licensee, certified addiction counselor, or unlicensed psychotherapist has violated a provision of Section 12-43-222, C.R.S. Addiction counselors are not required to report when reporting would violate individual/therapist confidentiality (see Section 12-43-218, C.R.S.).
- B. Reporting shall be in accordance with State Board of Addiction Counselor Examiners (4 CCR 744-1, Rule 6).

**21.330.92 Requirement to Update Personal Information [Eff. 11/1/13]**

All licensed or certified addiction counselors shall inform DORA in writing of changes to personal information in accordance with State Board of Addiction Counselor Examiners(4 CCR 744-1, Rule 8).

**21.400 - 21.700 (NONE)**

**21.800 UNIFORM METHOD OF DETERMINING ABILITY TO PAY FOR ANY PERSON WHO RECEIVES SERVICES FROM ANY PUBLIC INSTITUTION SUPERVISED BY THE DEPARTMENT OF HUMAN SERVICES FOR THE CARE, SUPPORT, MAINTENANCE, EDUCATION OR TREATMENT OF THE MENTALLY ILL OR DEVELOPMENTALLY DISABLED**

**21.810 STATUTORY AUTHORITY [Eff. 11/1/13]**

The statutory authority for these rules and regulations is found at Sections 27-92-101 through 27-92-109, C.R.S.

**21.820 DEFINITIONS [Eff. 11/1/13]**

“Ability to Pay” is the amount of the legally responsible person's income and assets available to pay for the individual cost of care, support, maintenance, treatment, and education at the institution.

“Adjusted Assets” is the balance of the assets of the legally responsible person(s) after allowed asset deductions.

“Adjusted Charge” is the charge for hospital care, support, maintenance and treatment, up to but not exceeding the ability to pay of the responsible person(s).

“Adjusted Income” is the balance of the total gross monthly income of the legally responsible person(s) after allowed income deductions.

“Allowed Asset Deduction” includes liabilities; the value of the equity in the home; assets which are specifically targeted for retirement and which are not available for other purposes; and the Supplemental Security Income (SSI) asset allowance for each legally responsible parent, patient, spouse, and other dependent.

“Allowed Income Deduction” includes withholding taxes, employee union or association dues, mandatory retirement deductions, health insurance premiums, conservator fees, one-twelfth of the federal personal exemption allowance for each dependent, and child support and/or alimony payments.

“Colorado Net Taxable Income” refers to the calculation on the State of Colorado Income Tax Form, and reportable under Colorado law, which is used as the base against which state tax liability is determined.

“Cost of Care” refers to the full rate multiplied by the number of days of care provided.

“Department” refers to the Colorado Department of Human Services.

“Dependent” is an individual who qualifies as a dependent under Internal Revenue Service (IRS) regulations for federal income tax purposes.

“Executive Director” refers to the Executive Director of the Department.

“Federal Personal Exemption Allowance” refers to the dollar amount allowed by the IRS for each dependent.

“Full Rate” refers to the institution's daily rate, which is determined periodically, based on the cost for care, support, maintenance, treatment and education of patients, as approved by the Executive Director.

“Institution” refers to any public institution of this state supervised by the Department of Human Services for the care, support, maintenance, education, or treatment of the mentally ill or developmentally disabled.

“Insurance and Other Benefits” includes all insurance, health maintenance organizations, Medicare, Medicaid, and any other resources covering the cost of care, support, maintenance, or treatment by the institution.

“Legally Responsible Person(s)” is the patient, fiduciary, spouse, and parent(s) of children under 18 years of age, as applicable.

“Patient” refers to any person admitted, committed or transferred to any public institution of this state supervised by the Department of Human Services for the care, support, maintenance, education or treatment of the mentally ill or developmentally disabled.

“Personal Needs Allowance” refers to the uniform dollar amount determined by the Department to be available to each patient receiving income from a benefit or employment, which may be used for items not provided by the institution.

“SSI Asset Allowance” refers to the maximum dollar amount of assets that an individual is allowed to retain and still qualify for the Supplemental Security Income (SSI) Program.

### **21.830 INTRODUCTION [Eff. 11/1/13]**

These rules are intended to provide the method used to assess charges at the public institutions under the supervision of the Department of Human Services for the care, support, maintenance, education, or treatment of the mentally ill or developmentally disabled. No person shall be denied admission because of inability to pay. These rules and regulations do not apply to individuals at these institutions who are receiving services under federally funded programs whose rules conflict with these rules.

### **21.840 PROCESS OF DETERMINING ABILITY TO PAY AND ADJUSTED CHARGE [Eff. 11/1/13]**

#### **A. Insurance and Other Benefits**

Insurance and other benefits shall be applied first to the cost of care. Insurance and other benefits for any patient shall be billed at the cost of care. A legally responsible person who fails to cooperate in making existing insurance and other benefits available for payment will nevertheless be considered as having benefits available for payment.

**B. Calculation of Ability to Pay**

The ability to pay shall be calculated taking into consideration the factors in Section 27-92-104, C.R.S., and using the schedule in Section 21.860 of these rules and regulations.

**C. Determination of Adjusted Charge**

The adjusted charge shall be the balance of the cost of care after insurance and other benefits have been deducted, or the ability to pay, whichever is less. If the legally responsible person(s) does not cooperate in making insurance and other benefits available, the legally responsible person(s) will be billed for the amount equal to the dollar value of the insurance or benefits in addition to the lesser of the balance of the cost of care or the ability to pay. If the dollar value of insurance and other benefits cannot be determined, the legally responsible person(s) will be billed the full cost of care.

**D. Modifications**

A legally responsible person whose income is substantially reduced as a result of changed financial circumstances after the ability to pay has been determined, may request a redetermination and provide the hospital with evidence of financial change so that a new ability to pay may be determined based on current income and assets.

Should there be an increase in income, assets, insurance or other benefits, this information must be reported to the institution within sixty (60) calendar days of the changed financial circumstances so that an appropriate redetermination of the ability to pay can be made.

**21.850 FACTORS AFFECTING THE DETERMINATION OF ABILITY TO PAY [Eff. 11/1/13]**

The following factors are considered in the determination of ability to pay, in accord with Section 27-92-104, C.R.S.

**A. Length of a Patient's Care and Treatment**

To avoid undue hardship on patients and/or their families, the ability to pay is reduced after the sixth calendar month of treatment.

**B. Medical and Physical Condition of Dependents**

To avoid undue hardship on families, monthly payments for medical services for dependents with serious mental or physical conditions may be deducted from income when the adjusted income is determined, provided adequate supporting documentation is submitted to the institution.

**21.860 SCHEDULE FOR DETERMINING THE ABILITY TO PAY [Eff. 11/1/13]**

The ability to pay of the legally responsible person(s) is the sum of the monthly adjusted income and the monthly adjusted assets available to pay for the cost of care, support, maintenance, treatment, and education at the institution.

The monthly adjusted assets considered available to pay for care, support, maintenance and treatment is one (1) percent of adjusted assets.

The following table is used to calculate the monthly adjusted income considered available to pay for care, support, maintenance, treatment, and education.

**MONTHLY ADJUSTED INCOME AVAILABLE TO PAY FOR CARE, SUPPORT, MAINTENANCE, TREATMENT AND EDUCATION**

<u>Adjusted Income</u>	<u>1st - 6th Calendar Months</u>	<u>7th and Subsequent Calendar Months</u>
	Percent of Adjusted Income Available	Percent of Adjusted Income Available
\$0-\$ 499	20%	15%
\$500-\$ 999	30%	25%
\$1,000 - \$1,499	35%	30%
\$1,500 - \$1,999	40%	35%
\$2,000 and above	45%	40%

**21.870 ADDITIONAL FACTORS AFFECTING THE ABILITY TO PAY AND THE ADJUSTED CHARGE [Eff. 11/1/13]**

- A. For legally responsible parents of children under eighteen (18) years of age, the monthly adjusted income available in the seventh and subsequent calendar months shall be one percent of Colorado Net Taxable Income.
- B. For single patients receiving only fixed income benefits, or when a husband and wife both reside in an institution or other health care facility and receive only fixed income benefits, the monthly adjusted income available will be the amount of these benefits, less the personal needs allowance and any other applicable deductions.

**21.900 COMPETENCY EVALUATIONS IN CRIMINAL CASES [Emergency eff. 11/6/15; Permanent eff. 2/1/16]**

These rules are established to create standards for psychologists and psychiatrists wishing to become approved as evaluators of competency to proceed.

**21.910 DEFINITIONS [Emergency eff. 11/6/15; Permanent eff. 2/1/16]**

“Approved evaluator” means an evaluator who is currently employed by CDHS; or has completed the application process through the Colorado Mental Health Institute at Pueblo (CMHIP) Court Services Division and is providing services under an active purchase order or a personal services contract, or as a fellow in forensic psychology or psychiatry training.

“Board Certification” in forensic psychiatry or forensic psychology means recognition of specialized training and knowledge in the field of forensic psychiatry by the American Board of Psychiatry and Neurology (ABPN), or in the field of forensic psychology by the American Board of Forensic Psychology (ABFP); no amendments or editions are incorporated. These board certification requirements may be reviewed during regular business hours by contacting the Superintendent of the Colorado Mental Health Institute in Pueblo, 1600 W. 24th Street, Pueblo, Colorado; or a state publications library.

“Competency Evaluator” means a licensed physician who is a psychiatrist or a licensed psychologist, each of whom is trained in forensic competency assessments, or a psychiatrist who is in forensic training and practicing under the supervision of a psychiatrist with expertise in forensic psychiatry and who is an approved evaluator, or a psychologist who is in forensic training and is practicing under the supervision of a licensed psychologist with expertise in forensic psychology and who is an approved evaluator.

“Competent to Proceed” means that the defendant does not have a mental disability or developmental disability that prevents the defendant from having sufficient present ability to consult with the defendant's lawyer with a reasonable degree of rational understanding in order to assist in the defense, or prevents the defendant from having a rational and factual understanding of the criminal proceedings.

“Court-Ordered Competency Evaluation” means a court-ordered examination of a defendant either before, during, or after trial, directed to developing information relevant to a determination of the defendant’s competency to proceed at a particular stage of the criminal proceeding, that is performed by a competency evaluator and includes evaluations concerning restoration to competency.

“Forensic” means relating to or dealing with the application of scientific knowledge to the legal issues of defendants in criminal proceedings.

“Incompetent to proceed” means that, as a result of a mental disability or developmental disability, the defendant does not have sufficient present ability to consult with the defendant’s lawyer with a reasonable degree of rational understanding in order to assist in the defense, or that, as a result of a mental disability or developmental disability, the defendant does not have a rational and factual understanding of the criminal proceedings.

**21.920 APPLICATION PROCESS [Emergency eff. 11/6/15; Permanent eff. 2/1/16]**

Individuals other than independent contractors or those providing services under an active purchase order or personal services contract wishing to become an approved evaluator shall contact the Director of Court Services at the Colorado Mental Health Institute at Pueblo (CMHIP) for application information, and the following shall be submitted to the CMHIP:

- A. A completed application form;
- B. Verification of licensure as a psychiatrist or psychologist;
- C. Verification of board certification in forensic psychiatry from the ABPN or board certification in forensic psychology from the ABFP, when relevant;
- D. Proof of current malpractice insurance;
- E. A minimum of two work samples, preferably forensic reports;
- F. A minimum of three professional references.

**21.930 TRAINING**

**21.931 APPROVED EVALUATORS [Emergency eff. 11/6/15; Permanent eff. 2/1/16]**

- A. All approved evaluators shall have received training as specified in these rules, consisting of at least six hours of classroom instruction. This initial training shall, at a minimum, cover the following elements:
  - 1. Legal background and legal standards for competency to proceed and competency to stand trial;
  - 2. Forensic versus clinical evaluation, ethical issues and challenges in competency evaluations, dual relationships, constitutional protections for defendants, informed consent in defendants with severe mental illnesses, and communication with attorneys;
  - 3. Interviewing for competency to proceed;
  - 4. Assessment of malingering;
  - 5. Use of third-party (collateral) data and resources;

6. Working with the difficult defendant;
7. Evaluating developmentally delayed defendants;
8. Special issues in evaluating juveniles;
9. Writing the competency or restoration report;
10. Acting as an expert witness; and,
11. Unique requests from the court, such as for evaluations for competency to waive the right to counsel.

**B. Exemptions to Initial Training**

1. Evaluators who are board certified in forensic psychiatry by the ABPN or board certified in forensic psychology by the ABFP shall be considered exempt from this initial training requirement.
2. Evaluators who are in forensic training and practicing under the supervision of a licensed psychiatrist who is an approved evaluator and who has expertise in forensic psychiatry, or a licensed psychologist who is an approved evaluator and who has expertise in forensic psychology, may practice without the initial training; however, it is expected that these evaluators will receive equivalent education during the course of their training programs.
3. Independent contractors or individuals providing services under an active purchase order or personal services contract are not subject to the training requirements in Section 21.931, A.

**C. Ongoing Training**

Approved evaluators other than independent contractors or individuals providing services under an active purchase order or personal services contract shall participate in at least four hours of ongoing training annually. Training will be made available at least annually by staff of the Court Services Division; alternative training to fulfill this requirement may be substituted for that offered by the Court Services Division, with prior approval from the Director of Court Services.

**21.932 MENTORING [Emergency eff. 11/6/15; Permanent eff. 2/1/16]**

Mentoring shall be made available to approved CDHS-employed evaluators. Mentoring will be provided by senior clinical staff from the CMHIP Court Services Division whenever possible.

- A. Approved CDHS-employed evaluators wishing to participate in mentoring will be provided the opportunity to observe one or more evaluations being conducted by senior clinical staff of CMHIP Court Services, and to conduct one or more evaluations while being observed by senior clinical staff of the CMHIP Court Services Division.
- B. Approved CDHS-employed evaluators wishing to participate in mentoring shall be required to travel to CMHIP to receive this additional training.

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**21.940 STANDARDS FOR CONDUCTING EVALUATIONS AND ESTABLISHING A REPORT**  
**[Emergency eff. 11/6/15; Permanent eff. 2/1/16]**

Each report shall conform with the requirements for report content as set forth in Section 16-8.5-105(5), C.R.S., and in accordance with best practices for forensic assessment of competency to stand trial.

**21.950 QUALITY ASSURANCE [Rev. eff. 11/6/15]**

All approved evaluators shall have one or more of their competency or restoration reports reviewed at least annually by a senior CMHIP Court Services Division evaluator or his or her designee.

- A. All approved evaluators shall have their first two reports reviewed by the senior CMHIP Court Services Division evaluator, or his or her designee, with additional reports being reviewed as necessary.
- B. Any and all reports submitted by approved evaluators are subject to review.

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**Editor's Notes**

**History**

Rules SB&P, 19.500 eff. 11/01/2007.

Rules SB&P, 19.421.3 eff. 09/01/2013.

Entire rule eff. 11/01/2013.

Rules SB&P, 21.900-21.950 emer. rules eff. 11/06/2015.

Rules SB&P, 21.900-21.950 eff. 02/01/2016.

Rules SB&P, 21.000-21.120.35, 21.190-21.210.59, 21.230-21.280.25, 21.330-21.330.2 eff. 05/01/2016.